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THE STANDARD EDITION OF
THE COMPLETE PSYCHOLOGICAL WORKS
OF SIGMUND FREUD

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VOLUME II



SIGMUND FREUD IN 1891

THE STANDARD EDITION
OF THE COMPLETE PSYCHOLOGICAL WORKS OF

SIGMUND FREUD

Translated from the German under the General Editorship of

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In Collaboration with

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Assisted by

ALIX STRACHEY and ALAN TYSON

VOLUME II

(1893–1895)

Studies on Hysteria

by

JOSEF BREUER AND SIGMUND FREUD

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A. ÜBER DEN PSYCHISCHEN MECHANISMUS HYSTERISCHER PHÄNOMENE (VORLÄUFIGE MITTEILUNG)

(a) GERMAN EDITIONS:

1893 *Neurol. Centralbl.*, 12 (1), 4–10 (Sections I–II), and 12 (2), 43–7 (Sections III–V). (January 1 and 15.)

1893 *Wien. med. Blätter*, 16 (3), 33–5 (Sections I–II), and 16 (4), 49–51 (Sections III–V). (January 19 and 26.)

1895, etc. In *Studien über Hysterie*. (See below.)

1906 *S.K.S.N.*, I, 14–29. (1911, 2nd. ed., 1920, 3rd. ed., 1922, 4th. ed.)

(b) ENGLISH TRANSLATIONS:

'The Psychic Mechanism of Hysterical Phenomena (Preliminary Communication)'

1909 *S.P.H.*, 1–13. (Tr. A. A. Brill.) (1912, 2nd. ed., 1920, 3rd. ed.)

1936 In *Studies in Hysteria*. (See below.)

'On the Psychical Mechanism of Hysterical Phenomena'

1924 *C.P.*, 1, 24–41. (Tr. J. Rickman.)

B. STUDIEN ÜBER HYSTERIE

(a) GERMAN EDITIONS:

1895 Leipzig and Vienna: Deuticke. Pp. v + 269.

1909 2nd. ed. Same publishers. (Unchanged, but with new preface.) Pp. vii + 269.

1916 3rd. ed. Same publishers. (Unchanged.) Pp. vii + 269.

1922 4th. ed. Same publishers. (Unchanged.) Pp. vii + 269.

1925 *G.S.*, 1, 3–238. (Omitting Breuer's contributions; with extra footnotes by Freud.)

1952 *G.W.*, 1, 77–312. (Reprint of 1925.)

(*b*) English Translations

Studies in Hysteria

1909 *S.P.H.*, 1–120. (1912, 2nd ed.; 1920, 3rd ed.; 1922, 4th ed.) (Tr. A. A. Brill.) (In part only: omitting the case histories of Fräulein Anna O., Frau Emmy von N. and Katharina, as well as Breuer's theoretical chapter.)

1936 New York: Nervous and Mental Disease Publishing Co. (Monograph Series No. 61.) Pp. ix + 241. (Tr. A. A. Brill.) Complete, except for omitting Freud's extra footnotes of 1925.)

The present, entirely new and complete translation by James and Alix Strachey includes Breuer's contributions, but is otherwise based on the German edition of 1925, containing Freud's extra footnotes. The omission of Breuer's contributions from the two German collected editions (*G.S.* and *G.W.*) led to some necessary changes and additional footnotes in them, where references had been made by Freud in the original edition to the omitted portions. In these collected editions, too, the numbering of the case histories was altered, owing to the absence of that of Anna O. All these changes are disregarded in the present translation.—Abstracts both of the 'Preliminary Communication' and of the main volume were included in Freud's early collection of abstracts of his own works (1897*b*, Nos. XXIV and XXXI).

(1)

Some Historical Notes on the Studies

The history of the writing of this book is known to us in some detail.

Breuer's treatment of Fräulein Anna O., on which the whole work was founded, took place between 1880 and 1882. By that time Josef Breuer (1842–1925) already had a high reputation in Vienna both as a physician with a large practice and as a man of scientific attainments, while Sigmund Freud (1856–1939) was only just qualifying as a doctor.[1] The two men had,

[1] Much of the material in what follows is derived from Ernest Jones's *Life of Freud*, Vol. I, and especially Chapter XI.

however, already been friends for some years. The treatment ended early in June, 1882, and in the following November Breuer related the remarkable story to Freud, who (though at that time his main interests were centred on the anatomy of the nervous system) was greatly impressed by it. So much so, indeed, that when, some three years later, he was studying in Paris under Charcot, he reported the case to him. 'But the great man showed no interest in my first outline of the subject, so that I never returned to it and allowed it to pass from my mind.' (*An Autobiographical Study*, 1925*d*, Chapter II.)

Freud's studies under Charcot had centred largely on hysteria, and when he was back in Vienna in 1886 and settled down to establish a practice in nervous diseases hysteria provided a large proportion of his clientele. To begin with he relied on such currently recommended methods of treatment as hydrotherapy, electro-therapy, massage and the Weir Mitchell rest-cure. But when these proved unsatisfactory his thoughts turned elsewhere. 'During the last few weeks', he writes to his friend Fliess on December 28, 1887, 'I have taken up hypnosis and have had all sorts of small but remarkable successes.' (Freud, 1950*a*, Letter 2.) And he has given us a detailed account of one successful treatment of this kind (1892–93*b*). But the case of Anna O. was still at the back of his mind, and 'from the first', he tells us (1925*d*), 'I made use of hypnosis in another manner, apart from hypnotic suggestion.' This 'other manner' was the cathartic method, which is the subject of the present volume.

The case of Frau Emmy von N. was the first one, as we learn from Freud (pp. 48 and 284), which he treated by the cathartic method.[1] In a footnote added to the book in 1925 he qualifies this and says it was the first case in which he made use of that method 'to a large extent' (p. 105), and it is true that at this early date he was still constantly employing hypnosis in the conventional manner—for giving direct therapeutic suggestions. At about this time, indeed, his interest in hypnotic suggestion was strong enough to lead him to translate two of Bernheim's books (1888–9 and 1892), as well as to

[1] A remark on p. 178 n. seems to imply on the other hand that the case of Frau Cäcilie M., mentioned below, preceded that of Frau Emmy. But this impression may perhaps be due to an ambiguity in the phrasing of the sentence.

pay a visit of some weeks to the clinics of Liébeault and Bernheim at Nancy in the summer of 1889. The extent to which he was using therapeutic suggestion in the case of Frau Emmy is shown very clearly by his day-to-day report of the first two or three weeks of the treatment, reproduced by him from 'the notes which I made each evening' (p. 48). We cannot unluckily be certain when he began this case (see Appendix A, p. 307), but it was in May either of 1888 or of 1889—that is, either about four or about sixteen months after he had first taken up hypnotism. The treatment ended a year later, in the summer of 1889 or 1890. In either alternative there is a considerable gap before the date of the next case history in chronological order (though not in order of presentation). This was the case of Fräulein Elisabeth von R., which began in the autumn of 1892 (p. 135) and which Freud describes (p. 139) as his 'first full-length analysis of a hysteria'. It was soon followed by that of Miss Lucy R., which began at the end of the same year (p. 106).[1] No date is assigned to the remaining case, that of Katharina (p. 125). But in the interval between 1889 and 1892 Freud certainly had experience with other cases. In particular there was that of Frau Cäcilie M., whom he 'got to know far more thoroughly than any of the other patients mentioned in these studies' (p. 69 n.), but whose case could not be reported in detail owing to 'personal considerations'. She is, however, frequently discussed by Freud, as well as by Breuer, in the course of the volume, and we learn (p. 178) from Freud that 'it was the study of this remarkable case, jointly with Breuer, that led directly to the publication of our "Preliminary Communication"'.[2]

[1] It is to be noted that neither of these last two analyses had been more than started at the time of the publication of the 'Preliminary Communication'.

[2] The question of when it was that Freud first began using the cathartic method is complicated still further by a statement made by him in 1914. The circumstances were these. At the International Medical Congress held in London in 1913, Pierre Janet had distinguished himself by making an absurdly ignorant and unfair attack on Freud and psycho-analysis. A reply was published by Ernest Jones in the *Journal of Abnormal Psychology*, 9 (1915), 400, and a German translation of this appeared in the *Int. Z. Psychoanal.*, 4 (1916), 34. In the course of his attack Janet had said that whatever was of the slightest value in psycho-analysis was entirely derived from his own early writings, and in contravening this assertion Jones had remarked that, though

The drafting of that epoch-making paper [illegible] in June 1892. A letter to [illegible] Letter [illegible] that Breuer has agreed [illegible] [illegible] ... 'A part of [illegible] I at first wanted [illegible] is finished.' [illegible] referred to again in a letter to Breuer [illegible] [illegible] given was [illegible] This letter goes on to give a very condensed summary of the [illegible] of the paper. Next we have a [illegible] Charcot's *Leçons du Mardi* [illegible] [illegible] in three short paragraphs [illegible] [illegible] have survived.[2] The first [illegible] handwriting [illegible] stated to have been [illegible]

[illegible]

Fräulein Elisabeth.

[1] [illegible]

[2] All of these drafts [illegible] will be found [illegible] volume of the *Standard Edition*.

Breuer, is dated 'End of November 1892'. It deals with hysterical attacks and its contents were mostly included, though in different words, in Section IV of the 'Preliminary Communication' (p. 13 ff.). One important paragraph, however, concerned with the 'principle of constancy', was unaccountably omitted, and in this volume the topic is treated only by Breuer, in the later part of the work (p. 197 ff.). Lastly, there is a memorandum (Freud, 1941b) bearing the title 'III'. This is undated. It discusses 'hypnoid states' and hysterical dissociation and is closely related to Section III of the published paper (p. 11 ff.).

On December 18, 1892 Freud wrote to Fliess (1950a, Letter 11): 'I am delighted to be able to tell you that our theory of hysteria (reminiscence, abreaction, etc.) is going to appear in the *Neurologisches Centralblatt* on January 1, 1893, in the form of a detailed preliminary communication. It has meant a long battle with my partner.' The paper, bearing the date 'December 1892', was actually published in two issues of the periodical: the first two Sections on January 1 and the remaining three on January 15. The *Neurologisches Centralblatt*, which appeared fortnightly, was published in Berlin, and the 'Preliminary Communication' was almost immediately reprinted in full in Vienna in the *Wiener medizinische Blätter* on January 19 and 26. On January 11, while the paper was only half published, Freud gave a lecture on its subject matter at the Wiener medizinischer Club. A full shorthand report of the lecture, revised by the lecturer, appeared in the *Wiener medizinische Presse* on January 22 and 29 (34, 122-6 and 165-7). The lecture (Freud, 1893h) covered approximately the same ground as the paper, but dealt with the material quite differently and in a much less formal manner.

The appearance of the paper seems to have produced little manifest effect in Vienna or Germany. In France, on the other hand, as Freud reports to Fliess in a letter of July 10, 1893 (1950a, Letter 13), it was favourably noticed by Janet, whose resistance to Freud's ideas was only to develop later. Janet included a long and highly laudatory account of the 'Preliminary Communication' in a paper on 'Some Recent Definitions of Hysteria' published in the *Archives de Neurologie* in June and July 1893. He used this paper as the final chapter of his book, *L'état mental des hystériques*, published in 1894. More unexpected,

perhaps is the fact that in April 1893, only three months after the publication of the 'Preliminary Communication', a fairly full account of it was given by F. W. H. Myers at a general meeting of the Society for Psychical Research in London and was printed in their *Proceedings* in the following June. The 'Preliminary Communication' was also fully abstracted and discussed by Mitchell Clarke in *Brain* (1894, 125). The most surprising and unexplained reaction, however, was the publication in February and March 1893, in the *Gaceta médica de Granada* (11, 105-11 and 129-35), of a complete translation of the 'Preliminary Communication', in Spanish.

The authors' next task was the preparation of the case material, and already on February 7, 1894, Freud spoke of the book as 'half finished: what remains to be done is only a small minority of the case histories and two general chapters'. In an unpublished passage in the letter of May 21 he mentions that he is just writing the last case history, and on June 22 (1950a, Letter 19) he gives a list of what 'the book with Breuer' is to contain: 'five case histories, an essay by him, with which I have nothing at all to do, on the theories of hysteria (summarizing and critical), and one by me on therapy which I have not started yet.' After this there was evidently a hold-up, for it is not until March 4, 1895 (ibid., Letter 22) that he writes to say that he is 'hurriedly working at the essay on the therapy of hysteria', which was finished by March 13 (unpublished letter). In another unpublished letter, of April 10, he sends Fliess the second half of the proofs of the book, and next day tells him it will be out in three weeks.

The *Studies on Hysteria* seem to have been duly published in May 1895, though the exact date is not stated. The book was unfavourably received in German medical circles; it was, for instance, very critically reviewed by Adolf von Strümpell, the well-known neurologist (*Deutsch. Z. Nervenheilk.*, 1896, 159). On the other hand, a non-medical writer, Alfred von Berger, later director of the Vienna Burgtheater, wrote appreciatively of it in the *Neue Freie Presse* (February 2, 1896). In England it was given a long and favourable notice in *Brain* (1896, 401) by Mitchell Clarke, and once again Myers showed his interest in it in an address of considerable length, first given in March 1897, which was ultimately included in his *Human Personality* (1903).

It was more than ten years before there was a call for a second edition of the book, and by that time the paths of its two authors had diverged. In May 1906 Breuer wrote to Freud agreeing on a reprint, but there was some discussion about whether a new joint preface was desirable. Further delays followed, and in the end, as will be seen below, two separate prefaces were written. These bear the date of July 1908, though the second edition was not actually published till 1909. The text was unaltered in this and the later editions of the book. But in 1924 Freud wrote some additional footnotes for the volume of his collected works containing his share of the *Studies* (published in 1925) and made one or two small changes in the text.

(2)

The Bearing of the Studies on Psycho-Analysis

The *Studies on Hysteria* are usually regarded as the starting-point of psycho-analysis. It is worth considering briefly whether and in what respects this is true. For the purposes of this discussion the question of the shares in the work attributable to the two authors will be left on one side for consideration below, and the book will be treated as a whole. An enquiry into the bearing of the *Studies* upon the subsequent development of psycho-analysis may be conveniently divided into two parts, though such a separation is necessarily an artificial one. To what extent and in what ways did the technical procedures described in the *Studies* and the clinical findings to which they led pave the way for the practice of psycho-analysis? To what extent were the theoretical views propounded here accepted into Freud's later doctrines?

The fact is seldom sufficiently appreciated that perhaps the most important of Freud's achievements was his invention of the first instrument for the scientific examination of the human mind. One of the chief fascinations of the present volume is that it enables us to trace the early steps of the development of that instrument. What it tells us is not simply the story of the overcoming of a succession of obstacles; it is the story of the *discovery* of a succession of obstacles that have to be overcome.

Breuer's patient Anna O. herself demonstrated and overcame the first of these obstacles—the amnesia characteristic of the hysterical patient. When the existence of this amnesia was brought to light, there at once followed a realization that the patient's manifest mind was not the whole of it, that there lay behind it an unconscious mind (p. 45 ff.). It was thus plain from the first that the problem was not merely the investigation of conscious mental processes, for which the ordinary methods of enquiry used in everyday life would suffice. If there were also unconscious mental processes, some special instrument was clearly required. The obvious instrument for this purpose was hypnotic suggestion—hypnotic suggestion used, not for directly therapeutic purposes, but to persuade the patient to produce material from the unconscious region of the mind. With Anna O. only a slight use of this instrument seemed necessary. She produced streams of material from her 'unconscious', and all Breuer had to do was to sit by and listen to them without interrupting her. But this was not so easy as it sounds, and the case history of Frau Emmy shows at many points how difficult it was for Freud to adapt himself to this new use of hypnotic suggestion and to listen to all that the patient had to say without any attempt at interference or at making short cuts (e.g. pp. 60 n. and 62 n.). Not all hysterical patients, moreover, were so amenable as Anna O.; the deep hypnosis into which she fell, apparently of her own accord, was not so readily obtained with everyone. And here came a further obstacle: Freud tells us that he was far from being an adept at hypnotism. He gives us several accounts in this book (e.g. p. 107 ff.) of how he circumvented this difficulty, of how he gradually gave up his attempts at bringing about hypnosis and contented himself with putting his patients into a state of 'concentration' and with the occasional use of pressure on the forehead. But it was the abandonment of hypnotism that widened still further his insight into mental processes. It revealed the presence of yet another obstacle—the patients' 'resistance' to the treatment (pp. 154 and 268 ff.), their unwillingness to co-operate in their own cure. How was this unwillingness to be dealt with? Was it to be shouted down or suggested away? Or was it, like other mental phenomena, simply to be investigated? Freud's choice of this second path led him directly into the uncharted world which he was to spend his whole life in exploring.

In the years immediately following the *Studies* Freud abandoned more and more of the machinery of deliberate suggestion [cf. p. 110 n.] and came to rely more and more on the patient's flow of 'free associations'. The way was opened up to the analysis of dreams. Dream-analysis enabled him, in the first place, to obtain an insight into the workings of the 'primary process' in the mind and the ways in which it influenced the products of our more accessible thoughts, and he was thus put in possession of a new technical device—that of 'interpretation'. But dream-analysis made possible, in the second place, his own self-analysis and his consequent discoveries of infantile sexuality and of the Oedipus complex. All these things, apart from some faint hints,[1] still lay ahead. But he had already, in the last pages of this volume, come up against another obstacle in the way of the analysis—the patient's 'transference' (p. 301 ff.). He had already had a glimpse of its formidable nature and had even, perhaps, already begun to recognize that it was to prove not only an obstacle but also another major instrument of psycho-analytic technique.

The main theoretical position adopted by the authors of the Preliminary Communication seems on the surface a simple one. They hold that in the normal course of things, if an experience is accompanied by a large amount of 'affect', that affect is either 'discharged' in a variety of conscious reflex acts or becomes gradually worn away by association with other conscious mental material. In the case of hysterical patients, on the other hand (for reasons which we shall mention in a moment), neither of these things happens. The affect remains in a 'strangulated' state, and the memory of the experience to which it is attached is cut off from consciousness. The affective memory is thereafter manifested in hysterical symptoms, which may be regarded as 'mnemic symbols'—that is to say as symbols of the suppressed memory (p. 90 n.). Two principal reasons are suggested to explain the occurrence of this pathological outcome. One is that the original experience took place while the subject was in a particular dissociated state of mind described as a 'hypnoid state'; the other is that the experience was one which the subject's 'ego' regarded as 'incompatible' with itself

[1] See, for instance, the remarks on dreams in a footnote on p. 69 and a hint at the theory of free association on p. 56.

[illegible] itself disappears.

[illegible] saw the light of day.

[illegible]

endeavours to keep the quantity of excitation present in it as low as possible or at least to keep it constant' (Standard Ed., 18, 9). Breuer states it below (p. [illegible]) in very similar terms, but with a neurological twist, as a 'tendency to keep intracerebral excitation constant'. [illegible] he argues that [illegible] hysteria to the fact that they are [illegible] large quantities of excitation [illegible] for discharge in accordance with the [illegible] Similarly, too, traumatic experiences owe their [illegible] force to the fact that they produce quantities of excitation too large to be dealt with in the normal way. [illegible] theoretical position underlying the Studies is that the [illegible] necessity for abreacting affect and the pathogenic [illegible] are explained by the [illegible] general tendency (expressed in the principle of constancy) to keep the quantity of excitation constant.

It has often been thought that the authors of the Studies attributed the phenomena of hysteria [illegible] memories of them, and that [illegible] that Freud, after shifting the emphasis from [illegible] arrived at [illegible] view of the processes of the mind. It will be seen, however, from what has just been said that a [illegible] shaped the [illegible] as the [illegible] of trauma and abreaction. And when the time came [illegible] the horizon and for attributing a far greater importance [illegible] as contrasted with [illegible] there was no need to modify the basic hypothesis. Already [illegible] points out the part played by the [illegible] needs and [illegible] increases in excitation which can be discharged (p. [illegible]), and emphasizes the importance of the 'sexual instinct' as the most powerful source of persisting increases of excitation and consequently of neuroses' (p. [illegible]). Moreover the whole notion of [illegible] and the [illegible]

[1] The first statement of the principle [illegible] January [illegible] was as follows: 'If a person experiences a psychical impression, something in his nervous system which we will [illegible] the sum of excitation [illegible]. Now in every [illegible] there exists a tendency to diminish this sum of excitation once more, in order to preserve his health [illegible].'

incompatible ideas is explicitly based on the occurrence of unpleasurable increases of excitation. This leads to the further consideration that, as Freud points out in *Beyond the Pleasure Principle* (*Standard Ed.*, 18, 9 ff.), the 'pleasure principle' itself is closely bound up with the principle of constancy. He even goes further and declares (*ibid.*, 62) that the pleasure principle 'is a tendency operating in the service of a function whose business it is to free the mental apparatus entirely from excitation or to keep the amount of excitation in it constant or to keep it as low as possible'. The 'conservative' character which Freud attributes to the instincts in his later works, and the 'compulsion to repeat', are also seen in the same passage to be manifestations of the principle of constancy; and it becomes clear that the hypothesis on which these early *Studies on Hysteria* were based was still being regarded by Freud as fundamental in his very latest speculations.

(3)

The Divergences between the Two Authors

We are not concerned here with the personal relations between Breuer and Freud, which have been fully described in the first volume of Ernest Jones's biography, but it will be of interest to discuss briefly their *scientific* differences. The existence of such differences was openly mentioned in the preface to the first edition, and they were often enlarged upon in Freud's later publications. But in the book itself, oddly enough, they are far from prominent, and even though the 'Preliminary Communication' is the only part of it with an explicitly joint authorship, it is not easy to assign with certainty the responsibility for the origin of the various component elements of the work as a whole.

We can no doubt safely attribute to Freud the later technical developments, together with the vital theoretical concepts of resistance, defence and repression which arose from them. It is easy to see from the account given on p. 268 ff. how these concepts followed from the replacement of hypnosis by the pressure technique. Freud himself, in his 'History of the Psycho-Analytic Movement' (1914*d*), declares that 'the theory of repression is the foundation-stone on which the structure of

[illegible] and gives the same [illegible] as he does [illegible] the way in which it was arrived at. He also asserts his belief that he [illegible] [illegible] and the [illegible] of the [illegible]. He remarks in the same passage that [illegible] to be [illegible] however he [illegible] the word [illegible] [illegible] Herbart [illegible]

As against this [illegible] that Breuer [illegible] terms 'catharsis' and 'abreaction'.

But [illegible] between [illegible] during their years of [illegible] and Breuer [illegible] determining [illegible] Breuer [illegible] of which [illegible] Breuer was a prominent member. [illegible] of the [illegible] in the [illegible] of physical and chemical forces.[1]

We have [illegible] that though Breuer was the [illegible] by [illegible] Freud. He [illegible]

[1] The [illegible] have played a part in [illegible] the [illegible] Freud [illegible]

[illegible] psychical processes (p. 194 [illegible]

[illegible] the nervous system').

[illegible]

The neurological bias of Freud's theories at this period is further shown by the form in which the principle of constancy is stated in the same passage in the 'Project'. It is given the name of 'the principle of neuronic inertia' and is defined as asserting that neurones tend to divest themselves of quantity. A remarkable paradox is thus revealed. Breuer, as we have seen (p. 185), declares his intention of treating the subject of hysteria on purely psychological lines: 'In what follows little mention will be made of the brain and none whatever of molecules. Psychical processes will be dealt with in the language of psychology.' But in fact his theoretical chapter is entirely concerned with 'intracerebral excitations' and with parallels between the nervous system and electrical installations. On the other hand Freud was devoting all his energies to explaining mental phenomena in physiological and chemical terms. Nevertheless, as he himself somewhat ruefully confesses (p. 160), his case histories read like short stories and his analyses are psychological ones.

The truth is that in 1895 Freud was at a half-way stage in the process of moving from physiological to psychological explanations of psychopathological states. On the one hand he was proposing what was roughly speaking a chemical explanation of the 'actual' neuroses—neurasthenia and anxiety neurosis—(in his two papers on anxiety neurosis [1895b and 1895f]), and on the other hand he was proposing an essentially psychological explanation—in terms of 'defence' and 'repression'—of hysteria and obsessions (in his two papers on 'The Neuro-Psychoses of Defence' [1894a and 1896b]). His earlier training and career as a neurologist led him to resist the acceptance of psychological explanations as ultimate, and he was engaged in devising a complicated structure of hypotheses intended to make it possible to describe mental events in purely neurological terms. This attempt culminated in the 'Project' and was not long afterwards abandoned. To the end of his life, however, Freud continued to adhere to the chemical aetiology of the 'actual' neuroses and to believe that a physical basis for all mental phenomena might ultimately be found. But in the meantime he gradually came round to the view expressed by Breuer that psychical processes can only be dealt with in the language of psychology. It was not until 1905 (in his book on jokes, Chapter VI) that he first explicitly repudiated all inten-

tion of using the term 'unconscious' in any but a psychological sense and his attempts at equating nerve tracts or neurones with paths of ideational association.[1]

What, however, were the essential scientific differences between Breuer and Freud? In his [illegible] Freud says that the first of these related to the aetiology of hysteria and [illegible] be described as [illegible] states versus neuroses of defence'. But once again in this volume the issue is less clear-cut. In the joint 'Preliminary Communication' both aetiologies are accepted [illegible]. Breuer in his theoretical chapter [illegible] lays most emphasis on hypnoid states [illegible], but he also stresses the importance of 'defence' [illegible]. Freud seems to accept the notion of 'hypnoid states' in his Katharina case history [illegible] and less [illegible] in that of [illegible] (p. [illegible]). It is only in his final chapter that his scepticism begins to be apparent (p. [illegible]). In a paper on 'The Aetiology of Hysteria', published in the following year [illegible], this scepticism is still more openly expressed, and in a footnote to his 'Dora' case history [illegible] he declares that the term 'hypnoid states' is superfluous and misleading' and that the hypothesis 'sprang entirely from the initiative of Breuer' (*Standard Ed.*, 7, 27 *n.*).

But the chief difference of opinion between the two authors upon which Freud later insisted concerned the part played by sexual impulses in the [illegible]. Here too, however, the *expressed* difference will be found less clear than would be expected. Freud's belief in the sexual [illegible] of hysteria can be [illegible] from his discussion [illegible] that he [illegible] asserts, as he was [illegible] that all cases of hysteria [illegible] sexual [illegible] was

[1] The [illegible] of [illegible] which Freud was at [illegible] the [illegible] that he felt [illegible] years [illegible] the very last [illegible] he [illegible] In [illegible] the [illegible] system [illegible] he [illegible] Yet [illegible] was [illegible] a [illegible] in the least [illegible] the meaning of the [illegible] has already been [illegible] more than [illegible] of the [illegible]

[2] As he already [illegible] The Neuro-Psychoses of Defence [illegible] and in the memorandum [illegible] almost certainly written in [illegible]; see above p. [illegible]

are invariably present.[1] On the other hand, Breuer speaks at several points in the strongest terms of the importance of the part played by sexuality in the neuroses, particularly in the long passage on p. 244 ff. He says for instance (as has already been remarked on p. xxv) that 'the sexual instinct is undoubtedly the most powerful source of persisting increases of excitation (and consequently of neuroses)' (p. 200), and declares (p. 246) that 'the great majority of severe neuroses in women have their origin in the marriage bed'.

It seems as though a further explanation of their divergence must be sought. Perhaps we should not take too literally the printed words. From Freud's letters to Fliess it seems as though Breuer was a man full of doubts and reservations, always uncertain in his conclusions. There is an extreme instance of this in a letter of November 8, 1895, some six months after the publication of the Studies: 'Not long ago Breuer made a big speech about me at the Doktorenkollegium, in which he announced his conversion to belief in the sexual aetiology [of the neuroses]. When I took him on one side to thank him for it, he destroyed my pleasure by saying: "But all the same I don't believe it." Can you understand that? I can't.' Something of the kind can be read between the lines of Breuer's contributions to the Studies, and we have the picture of a man half-afraid of his own remarkable discoveries. It was inevitable that he should be even more disconcerted by the premonition of still more unsettling discoveries yet to come; and it was inevitable that Freud in turn should feel hampered and irritated by his collaborator's uncertain hesitations.

It would be tedious to enumerate the many passages in Freud's later writings in which he refers to the *Studies on Hysteria* and to Breuer. But a few quotations will illustrate the varying emphasis in his attitude to them.

In the comments he made about some of his therapeutic methods and, still more, in his theories which he began to develop during the years immediately succeeding the issue of the *Studies*, he was at pains to emphasize the differences between psycho-analysis and the cathartic method: the technique of free association, the extension of

[1] Even at the end of the fourth of his *Five Lectures* (1910a) he categorically asserts that at the time of the publication of the *Studies* he did not yet believe that this was so.

[illegible] psycho-analysis.

[illegible]

[illegible]

[illegible]

[illegible]

PREFACE TO THE FIRST EDITION

In [illegible] we published a "Preliminary Communication" [illegible]

[illegible]

[illegible] to leave unpublished.

[illegible]

[illegible]

[illegible] differences between [illegible]

[illegible]

[illegible]

are agreed upon the facts and their basic reading of them, but who are not invariably at one in their interpretations and conjectures.

J. Breuer, S. Freud

April 1895

PREFACE TO THE SECOND EDITION

The interest which, to an ever-increasing degree, is being directed to psycho-analysis seems now to be extending to these *Studies on Hysteria*. The publisher desires to bring out a new edition of the book, which is at present out of print. It appears now in a reprint, without any alterations, though the opinions and methods which were put forward in the first edition have since undergone far-reaching and profound developments. So far as I personally am concerned, I have since that time had no active dealings with the subject; I have had no part in its important development and I could add nothing fresh to what was written in 1895. So I have been able to do no more than express a wish that my two contributions to the volume should be reprinted without alteration.

Breuer

As regards my share of the book, too, the only possible decision was that the text of the first edition should be reprinted without alteration. The developments and changes in my views during the course of thirteen years of work have been too far-reaching for it to be possible to attach them to my earlier exposition without entirely destroying its essential character. Nor have I any reason for wishing to eliminate this evidence of my initial views. Even to-day I regard them not as errors but as valuable first approximations to knowledge which could only be fully acquired after long and continuous efforts. The attentive reader will be able to detect in the present book the germs of all that has since been added to the theory of catharsis: for instance, the part played by psychosexual factors and infantilism, the importance of dreams and of unconscious symbolism. And I can give no better advice to anyone interested in the development of catharsis into psycho-analysis than to begin with *Studies on Hysteria* and thus follow the path which I myself have trodden.

Freud

Vienna, *July* 1908

I

PRELIMINARY COMMUNICATION
(1893)

(BREUER AND FREUD)

I

ON THE PSYCHICAL MECHANISM OF HYSTERICAL PHENOMENA: PRELIMINARY COMMUNICATION (1893)[1]

(BREUER AND FREUD)

I

A CHANCE observation has led us, over a number of years, to investigate a great variety of different forms and symptoms of hysteria, with a view to discovering their precipitating cause—the event which provoked the first occurrence, often many years earlier, of the phenomenon in question. In the great majority of cases it is not possible to establish the point of origin by a simple interrogation of the patient, however thoroughly it may be carried out. This is in part because what is in question is often some experience which the patient dislikes discussing; but principally because he is genuinely unable to recollect it and often has no suspicion of the causal connection between the precipitating event and the pathological phenomenon. As a rule it is necessary to hypnotize the patient and to arouse his memories under hypnosis of the time at which the symptom made its first appearance; when this has been done, it becomes possible to demonstrate the connection in the clearest and most convincing fashion.

This method of examination has in a large number of cases produced results which seem to be of value alike from a theoretical and a practical point of view.

They are valuable theoretically because they have taught us

[1] As explained above in the preface to the first edition, this first chapter had appeared originally as a separate paper in 1893. It was reprinted not only in the present book, but also as the first of Freud's collected volumes of his shorter works, *Sammlung kleiner Schriften zur Neurosenlehre*, 1906. The following footnote was appended to this later reprint: '[Also printed as an introduction to *Studies on Hysteria*, 1895, in which J[osef] Breuer and I further developed the views expressed here and illustrated them by case histories.]'

during the years that follow

prayer in English. When subsequently a severe and highly complicated hysteria developed, she could only speak, write and understand English, while her native language remained unintelligible to her for eighteen months.[1] — The mother of a very sick child, which had at last fallen asleep, concentrated her whole will-power on keeping still so as not to waken it. Precisely on account of her intention she made a 'clacking' noise with her tongue. (An instance of 'hysterical counter-will'.) This noise was repeated on a subsequent occasion on which she wished to keep perfectly still; and from it there developed a tic which, in the form of a clacking with the tongue, occurred over a period of many years whenever she felt excited.[2] — A highly intelligent man was present while his brother had an ankylosed hip-joint extended under an anaesthetic. At the instant at which the joint gave way with a crack, he felt a violent pain in his own hip-joint, which persisted for nearly a year. — Further instances could be quoted.

In other cases the connection is not so simple. It consists only in what might be called a 'symbolic' relation between the precipitating cause and the pathological phenomenon — a relation such as healthy people form in dreams. For instance, a neuralgia may follow upon mental pain or vomiting upon a feeling of moral disgust. We have studied patients who used to make the most copious use of this sort of symbolization.[3] In still other cases it is not possible to understand at first sight how they can be determined in the manner we have suggested. It is precisely the typical hysterical symptoms which fall into this class, such as hemi-anaesthesia, contraction of the field of vision, epileptiform convulsions, and so on. An explanation of our views on this group must be reserved for a fuller discussion of the subject.

Observations such as these seem to us to establish an analogy between the pathogenesis of common hysteria and that of traumatic neuroses, and to justify an extension of the concept of traumatic hysteria. In traumatic neuroses the operative cause of the illness is not the trifling

[1] [This patient is the subject of the first case history below, p. 21 ff.]

[2] [illegible]

[3] [See the account of Frau Cäcilie M., p. [illegible] ff. below.]

phenomenon is merely that the affect of fright—the psychical trauma. In an analogous manner, our investigations reveal, for many, if not for most, hysterical symptoms, precipitating causes which can only be described as psychical traumas. Any experience which calls up distressing affects—such as those of fright, anxiety, shame or physical pain—may operate as a trauma of this kind; and whether it in fact does so depends naturally enough on the susceptibility of the person affected (as well as on another condition which will be mentioned later). In the case of common hysteria it not infrequently happens that, instead of a single, major trauma, we find a number of partial traumas forming a *group* of provoking causes. These have only been able to exercise a traumatic effect by summation and they belong together in so far as they are in part components of a single story of suffering. There are other cases in which an apparently trivial circumstance combines with the actually operative event or occurs at a time of peculiar susceptibility to stimulation and in this way attains the dignity of a trauma which it would not otherwise have possessed but which thenceforward persists.

But the causal relation between the determining psychical trauma and the hysterical phenomenon is not of a kind implying that the trauma merely acts like an *agent provocateur* in releasing the symptom, which thereafter leads an independent existence. We must presume rather that the psychical trauma—or more precisely the memory of the trauma—acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work; and we find the evidence for this in a highly remarkable phenomenon which at the same time lends an important *practical* interest to our findings.

For we found, to our great surprise at first, that *each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words.* Recollection without affect almost invariably produces no result. The psychical process which originally took place must be repeated as vividly as possible; it must be brought back to its *status nascendi* and then given verbal utterance. Where what we are dealing with are phenom-

by a method analogous to ours.

I

[illegible]

tone to begin with.

[illegible]

1950a, Letter 9).]

experiences [pp. 178-80].

[illegible] we find are the [illegible] [illegible] in [illegible] and [illegible]

[illegible] are determined [illegible] the fact that [illegible]

impossible.

[illegible]

makes reaction impossible.

[illegible]

III

[illegible]

[illegible]

[illegible] total amnesia.

[illegible]

[illegible]

[1] [Pierre and Jules.]

hysteria. Between the extremes of these two forms we must assume the existence of a series of cases within which the liability to dissociation in the subject and the affective magnitude of the trauma vary inversely.

We have nothing new to say on the question of the origin of these dispositional hypnoid states. They often, it would seem, grow out of the day-dreams which are so common even in healthy people and to which needlework and similar occupations render women especially prone. Why it is that the 'pathological associations' brought about in these states are so stable and why they have so much more influence on somatic processes than ideas are usually found to do, coincides with the general problem of the effectiveness of hypnotic suggestions. Our observations contribute nothing fresh on this subject. But they throw a light on the contradiction between the dictum 'hysteria is a psychosis' and the fact that among hysterics may be found people of the clearest intellect, strongest will, greatest character and highest critical power. This characterization holds good of their waking thoughts; but in their hypnoid states they are insane, as we all are in dreams. Whereas, however, our dream-psychoses have no effect upon our waking state, the products of hypnoid states intrude into waking life in the form of hysterical symptoms.[1]

IV

What we have asserted of chronic hysterical symptoms can be applied almost completely to hysterical *attacks*. Charcot, as is well known, has given us a schematic description of the 'major' hysterical attack, according to which four phases can be distinguished in a complete attack: (1) the epileptoid phase, (2) the phase of large movements, (3) the phase of *attitudes passionnelles* (the hallucinatory phase), and (4) the phase of terminal delirium. Charcot derives all the forms of hysterical attack which are in practice met with more often than the complete *grande attaque* from the abbreviation, absence or isolation of these four distinct phases.[2]

[1] [A preliminary sketch of this section of the paper will be found in a posthumously published memorandum (Freud, 1940d), which is headed 'III'.]

[2] [Cf. Charcot, 1887, 26.]

Our attempted explanation takes its start from the third of these phases, that of the *attitudes passionnelles*. Where this is present in a well-marked form, it exhibits the hallucinatory reproduction of a memory which was of importance in bringing about the onset of the hysteria—the memory either of a single major trauma (which we find *par excellence* in what is called traumatic hysteria) or of a series of interconnected part-traumas (such as underlie common hysteria). Or, lastly, the attack may revive the events which have become emphasized owing to their coinciding with a moment of special disposition to trauma.

There are also attacks, however, which appear to consist exclusively of motor phenomena and in which the phase of *attitudes passionnelles* is absent. If one can succeed in getting into *rapport* with the patient during an attack such as this of generalized clonic spasms or cataleptic rigidity, or during an *attaque de sommeil* [attack of sleep]—or if, better still, one can succeed in provoking the attack under hypnosis—one finds that here, too, there is an underlying memory of the psychical trauma or series of traumas, which usually comes to our notice in a hallucinatory phase.

Thus, a little girl suffered for years from attacks of general convulsions which could well be, and indeed were, regarded as epileptic. She was hypnotized with a view to a differential diagnosis, and promptly had one of her attacks. She was asked what she was seeing and replied 'The dog! the dog's coming!'; and in fact it turned out that she had had the first of her attacks after being chased by a savage dog. The success of the treatment confirmed the choice of diagnosis.

Again, an employee who had become a hysteric as a result of being ill-treated by his superior, suffered from attacks in which he collapsed and fell into a frenzy of rage, but without uttering a word or giving any sign of a hallucination. It was possible to provoke an attack under hypnosis, and the patient then revealed that he was living through the scene in which his employer had abused him in the street and hit him with a stick. A few days later the patient came back and complained of having had another attack of the same kind. On this occasion it turned out under hypnosis that he had been re-living the scene to which the actual onset of the illness was related: the scene in the law-court when he failed to obtain satisfaction for his maltreatment.

In all other respects [illegible]

[illegible] to it under hypnosis.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] is touched on.

[illegible] any content.

[illegible]

[illegible]

[illegible]

V

[illegible] in these pages has [illegible]

[illegible] procedure [illegible] We can do [illegible] Moreover [illegible] have been [illegible] psycho-therapists.

[illegible]

VIENNA, *December* 1892

[illegible] hysterical attacks (1909*a*).]

II

CASE HISTORIES

(Breuer and Freud)

II

CASE HISTORIES

Breuer and Freud)

CASE 1

Fraulein Anna O. (Breuer)

[illegible]

which one person's life is seldom known to another, had never been in love; and in all the enormous number of hallucinations which occurred during her illness that element of mental life never emerged.

This girl, who was bubbling over with intellectual vitality, led an extremely monotonous existence in her puritanically-minded family. She embellished her life in a manner which probably influenced her decisively in the direction of her illness, by indulging in systematic day-dreaming, which she described as her 'private theatre'. While everyone thought she was attending, she was living through fairy tales in her imagination; but she was always on the spot when she was spoken to, so that no one was aware of it. She pursued this activity almost continuously while she was engaged on her household duties, which she discharged unexceptionably. I shall presently have to describe the way in which this habitual day-dreaming while she was well passed over into illness without a break.

The course of the illness fell into several clearly separable phases:

A. Latent incubation. From the middle of July, 1880, till about December 10th. This phase of an illness is usually hidden from us; but in this case, owing to its peculiar character, it was completely accessible; and this in itself lends no small pathological interest to the history. I shall describe this phase presently.

B. The manifest illness. A psychosis of a peculiar kind, paraphasia, a convergent squint, severe disturbances of vision, paralyses (in the form of contractures), complete in the right upper and both lower extremities, partial in the left upper extremity, paresis of the neck muscles. A gradual reduction of the contracture to the right-hand extremities. Some improvement, interrupted by a severe psychical trauma (the death of the patient's father) in April, after which there followed

C. A period of persisting somnambulism, subsequently alternating with more normal states. A number of chronic symptoms persisted till December, 1881.

D. Gradual cessation of the pathological states and symptoms up to June, 1882.

In July, 1880, the patient's father, of whom she was passionately fond, fell ill of a peripleuritic abscess which failed to clear

[illegible] which he [illegible] in [illegible] During the [illegible] Anna [illegible] energy [illegible] her [illegible] was [illegible] her [illegible] greatly [illegible] No one, perhaps not even the [illegible] knew what was happening [illegible] But [illegible] to her great [illegible] she was [illegible] The [illegible] was a very [illegible] examined her for the [illegible] It was a [illegible] She would [illegible] resting during the [illegible] in the evening [illegible] and afterwards [illegible] excited condition.

At the beginning of December a convergent squint appeared. An [illegible] explained this [illegible] On [illegible] the patient took to her bed and remained there [illegible]

There developed in rapid succession a series of severe disturbances which were [illegible] She [illegible] the neck [illegible] she [illegible] raise her head by pressing it backwards between her raised shoulders and moving her whole back. [illegible] the right [illegible] lower extremity [illegible] the left lower extremity [illegible] to make a [illegible] At the beginning of the [illegible] owing to the patient's resistance arising from [illegible] anxiety.

It was while the patient was in this condition that I undertook her treatment, and I at once recognized the seriousness

[1] [The French term.]

[illegible] hallucinatory '*absences*'.

[illegible] Shakespeare.

[illegible]

* [In English in the original.]

[illegible] such things.

[illegible] content of these hallucinations.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] verbal utterance to them.

[illegible]

[illegible] But it became possible gradually to reduce the dose.

[illegible] reported on in her hypnosis.

[illegible]

differed from each other precisely in this way: ... [illegible] ... further in that in the first she lived, like the rest of us, in the winter of 1881-2, whereas in the second she lived in the winter of 1880-1, and had completely forgotten all the subsequent events. [illegible]

[illegible]

* [In English in the original.]

[illegible]

[cf. below, pp. 44–5].

[illegible]

¹ [See footnote 2, p. 48.]

however, took a long time, in the evening hypnosis owing to her being over-strained and distraught by working out the two other sets of experiences—and owing, too, to the reminiscences needing time before they could attain full vividness—we evolved the following procedure. I used to visit her in the morning and hypnotize her. (Very simple methods of doing this were arrived at empirically.) I would next ask her to concentrate her thoughts on the symptom we were treating at the moment and to tell me the occasions on which it had appeared. The patient would proceed to describe in rapid succession and under brief headings the external events concerned and these I would jot down. During her subsequent evening hypnosis she would then, with the help of my notes, give me a fairly detailed account of these circumstances.

An example will show the exhaustive manner in which she accomplished this. It was our regular experience that the patient did not hear when she was spoken to. It was possible to differentiate this passing habit of not hearing as follows:

(*a*) Not hearing when someone came in, while her thoughts were abstracted. 108 separate detailed instances of this, mentioning the persons and circumstances, often with dates. First instance: not hearing her father come in.

(*b*) Not understanding when several people were talking. 27 instances. First instance: her father, once more, and an acquaintance.

(*c*) Not hearing when she was alone and directly addressed. 50 instances. Origin: her father having vainly asked her for some wine.

(*d*) Deafness brought on by being shaken (in a carriage, etc.). 15 instances. Origin: having been shaken angrily by her young brother when he caught her one night listening at the sick-room door.

(*e*) Deafness brought on by fright at a noise. 37 instances. Origin: a choking fit of her father's, caused by swallowing the wrong way.

(*f*) Deafness during deep *absence*. 12 instances.

(*g*) Deafness brought on by listening hard for a long time, so that when she was spoken to she failed to hear. 54 instances.

Of course all these episodes were to a great extent identical in so far as they could be traced back to states of abstraction or *absences* or to fright. But in the patient's memory they were so

as has already been explained, the patient was always in her 'second state'—that is, in the year 1881—at night. On one occasion she woke up during the night, declaring that she had been taken away from home once again, and became so seriously excited that the whole household was alarmed. The cause was simple. During the previous evening the talking cure had cleared up her disorder of vision, and this applied also to her second state. Thus when she woke up in the night she found herself in a strange room, for her family had moved house in the spring of 1881. Disagreeable events of this kind were avoided by my always (at her request) shutting her eyes in the evening and giving her a suggestion that she would not be able to open them till I did so myself on the following morning. The disturbance was only repeated once, when the patient cried in a dream and opened her eyes on waking up from it.

Since this laborious analysis for her symptoms dealt with the summer months of 1880, which was the preparatory period of her illness, I obtained complete insight into the incubation and pathogenesis of this case of hysteria, and I will now describe them briefly.

In July, 1880, while he was in the country, her father fell seriously ill of a subpleural abscess. Anna shared the duties of nursing him with her mother. She once woke up during the night in great anxiety about the patient, who was in a high fever; and she was under the strain of expecting the arrival of a surgeon from Vienna who was to operate. Her mother had gone away for a short time and Anna was sitting at the bedside with her right arm over the back of her chair. She fell into a waking dream and saw a black snake coming towards the sick man from the wall to bite him. (It is most likely that there were in fact snakes in the field behind the house and that these had previously given the girl a fright; they would thus have provided the material for her hallucination.) She tried to keep the snake off, but it was as though she was paralysed. Her right arm, over the back of the chair, had gone to sleep and had become anaesthetic and paretic; and when she looked at it the fingers turned into little snakes with death's heads (the nails). (It seems probable that she had tried to use her paralysed right arm to drive off the snake and that its anaesthesia and paralysis had consequently become associated with the hallucination of the snake.) When the snake vanished, in her terror

[illegible]

[illegible] similar occasion.

[illegible] with a *tussis nervosa*.

[illegible] its first occurrence.

[illegible]

[illegible]

It was a considerable time before she regained her mental balance entirely. Since then she has enjoyed complete health.

Although I have suppressed a large number of quite interesting details, this case history of Anna O. has grown bigger than would seem to be required for a hysterical illness that was not in itself of an unusual character. It was, however, impossible to describe the case without entering into details, and its features seem to me of sufficient importance to excuse this extensive report. In just the same way, the eggs of the echinoderm are important in embryology, not because the sea-urchin is a particularly interesting animal but because the protoplasm of its eggs is transparent and because what we observe in them throws light on the probable course of events in eggs whose protoplasm is opaque. The interest of the present case seems to me above all to reside in the extreme clarity and intelligibility of its pathogenesis.

There were two psychical characteristics present in the girl while she was still completely healthy which acted as predisposing causes for her subsequent hysterical illness:

(1) Her monotonous family life and the absence of adequate intellectual occupation left her with an unemployed surplus of mental liveliness and energy, and this found an outlet in the constant activity of her imagination.

(2) This led to a habit of day-dreaming (her 'private theatre'), which laid the foundations for a dissociation of her mental personality. Nevertheless a dissociation of this degree is still within the bounds of normal life. Reverie and re[illegible]

[illegible]

in Freud's researches

[illegible]

became more strongly entrenched by frequent repetition. In addition to this it gradually came about that any sudden distressing affect would have the same result as an absence (though, indeed, it is possible that such affects actually caused a temporary absence in every case). Chance coincidences set up pathological associations and sensory or motor disturbances, which from then onward appeared along with the affect. But hitherto this had only occurred for fleeting moments. Before the patient took to her bed she had already developed the whole assemblage of hysterical phenomena, without anyone knowing it. It was only after the patient had been brought to [illegible] exhaustion brought about by [illegible] and constant anxiety, and only after she had begun to pass more time in her condition seconde than in her normal state, that the hysterical phenomena extended to the latter as well and changed from intermittent acute symptoms into chronic ones.

The question now arises how far the patient's statements are trustworthy and whether the [illegible] as she [illegible] the [illegible] were really as she represented them. So far as the more important [illegible] and the former events are concerned the trustworthiness of her account seems to me to be beyond question. As regards the symptoms disappearing after being 'talked away', I cannot use this as evidence; it may very well be explained by suggestion. But I always found the patient entirely truthful and trustworthy. The things she told me were intimately bound up with what was most sacred to her. Whatever could be checked by other people was fully confirmed. Even the most highly gifted girl would be incapable of concocting a tissue of data with such a degree of internal consistency as was exhibited in the history of her case. It cannot be disputed, however, that precisely her consistency may have led her (in perfectly good faith) to assign to some of her symptoms a precipitating cause which they did not in fact possess. But this suspicion, too, I consider unjustified. The very insignificance of so many of those causes, the irrational character of so many of the connections involved, argue in favour of their reality. The patient could not understand how it was that dance music made her cough; such a construction is too meaningless to have been deliberate. It seemed [illegible] to me [illegible] caused her [illegible] brought [illegible]

[illegible] ring during a state of hypnosis.

[illegible]

[illegible]

[illegible] facts.

[illegible]

[illegible]

number of unexplained problems in many other hysterical patients. It was really astonishing to see how much the products of her 'bad self,' as she herself called it, affected her moral habit of mind. If these products had not been continually disposed of, we should have been faced by a hysteric of the malicious type—refractory, lazy, disagreeable and ill-natured; but, as it was, after the removal of those stimuli her true character, which was the opposite of all these, always reappeared at once.

Nevertheless, though her two states were thus sharply separated, not only did the secondary state intrude into the first one, but—and this was at all events frequently true, and even when she was in a very bad condition—a clear-sighted and calm observer sat, as she put it, in a corner of her brain and looked on at all the mad business. This persistence of clear thinking while the psychosis was actually going on found expression in a very curious way. At a time when, after the hysterical phenomena had ceased, the patient was passing through a temporary depression, she brought up a number of childish fears and self-reproaches, and among them the idea that she had not been ill at all and that the whole business had been simulated. Similar observations, as we know, have frequently been made. When a disorder of this kind has cleared up and the two states of consciousness have once more become merged into one, the patients, looking back to the past, see themselves as the single undivided personality which was aware of all the nonsense; they think they could have prevented it if they had wanted to, and thus they feel as though they had done all the mischief deliberately.—It should be added that this normal thinking which persisted during the secondary state must have fluctuated enormously in its amount and must very often have been completely absent.

I have already described the astonishing fact that from beginning to end of the illness all the stimuli arising from the secondary state, together with their consequences, were permanently removed by being given verbal utterance in hypnosis, and I have only to add an assurance that this was not an invention of mine which I imposed on the patient by suggestion. It took me completely by surprise, and not until symptoms had been got rid of in this way in a whole series of instances did I develop a therapeutic technique out of it.

The final cure of the hysteria deserves a few more words. It was accompanied, as I have already said, by considerable disturbances and a deterioration in the patient's mental condition. I had a very strong impression that the numerous products of her secondary state which had been quiescent were now forcing their way into consciousness, and though in the first instance they were being remembered only in her secondary state, they were nevertheless burdening and disturbing her normal one. It remains to be seen whether it may not be that the same origin is to be traced in other cases in which a chronic hysteria terminates in a psychosis.[1]

[1] [A very full summary and discussion of this case history occupies the greater part of the first of Freud's *Five Lectures* (1910*a*).]

CASE 2

Frau Emmy von N., age 40, from Livonia (Freud)

On May 1, 1889,[1] I took on the case of a lady of about forty years of age, whose symptoms and personality interested me so greatly that I devoted a large part of my time to her and determined to do all I could for her recovery. She was a hysteric and could be put into a state of somnambulism with the greatest ease; and when I became aware of this I decided that I would make use of Breuer's technique of investigation under hypnosis, which I had come to know from the account he had given me of the successful treatment of his first patient. This was my first attempt at handling that therapeutic method. I was still far from having mastered it; in fact I did not carry the analysis[2] of the symptoms far enough, nor pursue it systematically enough. I shall perhaps be able best to give a picture of the patient's condition and my medical procedure by reproducing the notes which I made each evening during the first three weeks of the treatment. Wherever later experience has brought me a better understanding, I shall embody it in footnotes and interpolated comments.

May 1, 1889.—This lady, when I first saw her, was lying on a sofa with her head resting on a leather cushion. She still looked young and had finely-cut features, full of character. Her face bore a strained and painful expression, her eyelids were drawn together and her eyes cast down; there was a heavy frown on her forehead and the naso-labial folds were deep. She spoke in a low voice as though with difficulty and her speech was

[1] [The chronology of this case history is not without its difficulties as it stands, and there is a fairly strong presumption that the treatment began a year earlier, in 1888. The dates which are given in all the German editions have been retained in the present translation, but they are evidently in need of correction. The question is discussed in Appendix A, p. 307.]

[2] [Freud had already used the term 'analysis' as well as 'psychical analysis', 'psychological analysis' and 'hypnotic analysis' in his first paper on the neuro-psychoses of defence (1894a). He only later introduced the word 'psycho-analysis' in a paper on the aetiology of the neuroses, written in French (1896a).]

married an extremely gifted and able man who had made a big position for himself as an industrialist on a large scale but was much older than she was. After a short marriage he died of a stroke. This event, together with the task of bringing up her two daughters, now sixteen and fourteen years old, who were often in ill-health and suffered from nervous troubles, she attributed her own illness. Since her husband's death, fourteen years ago, she has been constantly ill with varying degrees of severity. Four years ago her condition was temporarily improved by a course of massage combined with electric baths. Apart from this, all her efforts to regain her health have been unsuccessful. She has travelled a great deal and has many lively interests. She lives at present at a country seat on the Baltic near a large town.[1] For several months she has once more been very ill, suffering from depression and insomnia and tormented with pains; she went to Abbazia[2] in the vain hope of an improvement, and for the last six weeks has been in Vienna, up till now in the care of a physician of outstanding merit.

I suggested that she should separate from the two girls, who had their governess, and go into a nursing home where I could see her every day. This she agreed to without raising the slightest objection.

On the evening of May 2 I visited her in the nursing home. I noticed that she started violently whenever the door opened unexpectedly. I therefore arranged that the nurses and the house physicians, when they visited her, should give a loud knock at her door and not enter till she had told them to come in. But even so she still made a grimace and gave a jump every time anyone entered.

Her principal complaint today was of sensations of cold and pain in her right leg which proceeded from her back above the iliac crest. I ordered her to be given warm baths and I shall massage her whole body twice a day.

She is an excellent subject for hypnotism. I had only to hold up a finger in front of her and order her to go to sleep, and she sank back with a dazed and confused look. I suggested that she

[1] [illegible] There is reason to believe [illegible] had two [illegible] another part of Europe.]

[2] [illegible] at that time Austrian resort on the Adriatic.]

should sleep well, that all her symptoms should get better, and so on. She heard all this with closed eyes but with unmistakably concentrated attention, and her features gradually relaxed and took on a peaceful appearance. After this first hypnosis she retained a dim memory of my words; but already at the second there was complete somnambulism (with amnesia). I had warned her that I proposed to hypnotize her, to which she raised no difficulty. She has not previously been hypnotized, but it is safe to suppose that she has read about hypnotism, though I cannot tell what notions she may have about the hypnotic state.[1]

This treatment by warm baths, massage twice a day and hypnotic suggestion was continued for the next few days. She slept well, got visibly better, and passed most of the day lying quietly in bed. She was not forbidden to see her children, to read, or to deal with her correspondence.

May 8, morning.—She entertained me, in an apparently quite normal state, with gruesome stories about animals. She had read in the *Frankfurter Zeitung*, which lay on the table in front of her, a story of how an apprentice had tied up a boy and put a white mouse into his mouth. The boy had died of fright. Dr. K. had told her that he had sent a whole case of white rats to Tiflis. As she told me this she demonstrated every sign of horror. She clenched and unclenched her hand several times. 'Keep still! Don't say anything! Don't touch me!—Supposing a creature like that was in the bed!' (She shuddered.) 'Only think, when it's unpacked! There's a dead rat in among them—one that's been gn-aw-aw-ed at!'

During the hypnosis I tried to disperse these animal hallucinations. While she was asleep I picked up the *Frankfurter Zeitung*. I found the anecdote about the boy being maltreated,

[1] Every time she woke from hypnosis she looked about her for a moment in a confused way, let her eyes fall on me, seemed to have come to her senses, put on her glasses, which she took off before going to sleep, and then became quite lively and on the spot. Although in the course of the treatment (which lasted for seven weeks in this first year and eight in the second) we discussed every kind of subject, and although I put her to sleep twice almost every day, she never made any comment to me about the hypnosis or asked me a single question about it; and in her waking state she seemed, so far as possible, to ignore the fact that she was undergoing hypnotic treatment.

[illegible] heartily.[1]

[illegible] a couple of hours'.

[illegible]

[1] [illegible] age raised the topic of dates.

[2] A species of migraine. [See p. 71 n.]

my question and her answer. At the end of each separate story she twitched all over and took on a look of fear and horror. At the end of the last one she opened her mouth wide and panted for breath. The words in which she described the terrifying subject-matter of her experience were pronounced with difficulty and between gasps. Afterwards her features became peaceful.

In reply to a question she told me that while she was describing these scenes she saw them before her in a plastic form and in their natural colours. She said that in general she thought of these experiences very often and had done so in the last few days. Whenever she thought of them she saw these scenes with all the vividness of reality.[1] I now understood why she entertains me so frequently with pictures of animals and corpses. My therapy consists in wiping away these pictures, so that she is no longer able to see them before her. To give support to my suggestion I stroked her several times over the eyes.

May 9, morning.—Without my having given her any further suggestion she had slept well. But she had gastric pains in the morning. They came on yesterday in the garden where she stayed too long with her children. She agreed to my limiting her children's visit to two and a half hours. A few days ago she had reproached herself for leaving the children by themselves. I found her in a somewhat excited state to-day; her forehead was furrowed, her speech was halting and she made her clacking noises. While she was being massaged she told me only that the children's governess had brought her an ethnological atlas and that some pictures in it of American Indians dressed up as animals had given her a great shock. 'Only think, if they came to life!' (She shuddered.)

I then hypnotized her and asked why she had been so frightened by these pictures, since she was no longer afraid of animals. She said they had reminded her of visions she had had when she was nineteen at the time of her brother's death. I shall hold over the discussion of this memory till later. I then asked

[1] Many other hysterical patients have reported to us that they have memories of this kind in vivid visual pictures and that this is especially true of their pathogenic memories.

[2] [illegible] which in view of what [illegible]

[illegible]

that all these scenes appeared before her often, vividly and in colours. One of them was of how she saw a female cousin taken off to an insane asylum when she was fifteen. She tried to call for help but was unable to, and lost her power of speech till the evening of the same day. Since she talks so often about asylums in her waking state, I interrupted her and asked her what other occasions there had been concerned with insanity. She told me that her mother had herself been in an asylum for some time. They had once had a maidservant one of whose previous mistresses had spent a long time in an asylum and who used to tell her horrifying stories of how the patients were tied to chairs, beaten, and so on. As she told me this she clenched her hands in horror; she saw all this before her eyes. I endeavoured to correct her ideas about insane asylums, and assured her that she would be able to hear about institutions of this kind without relating them to herself. At this her features relaxed.

She continued her list of terrifying memories. One, at fifteen, of how she found her mother, who had had a stroke, lying on the floor (her mother lived for another four years); again, at nineteen, how she came home one day and found her mother dead, with a distorted face. I naturally had considerable difficulty in mitigating these memories. After a rather lengthy explanation I assured her that this picture, too, would only appear to her again indistinctly and without strength. Yet another memory was of how at nineteen she lifted up a stone and found a toad under it, which made her lose her power of speech for hours afterwards.[1]

During this hypnosis I convinced myself that she knew everything that happened in the last hypnosis, whereas in waking life she knows nothing of it.

May 10, morning. For the first time to-day she was given a bran bath instead of her usual warm bath. I found her looking cross and with a pinched face, with her hands wrapped in a shawl. She complained of cold and pains. When I asked her what was the matter, she told me that the bath had been uncomfortably short in length and had brought on pains. During the massage she started by saying that she still felt bad about having given Dr. Breuer away yesterday. I pacified her with a

[1] A special kind of symbolism must, no doubt, have lain behind the toad, but I unfortunately neglected to enquire into it.

[illegible]

[illegible] method of free association.]

how, at another time, an acquaintance had suddenly gone mad in the house and had caught her by the arm. (There was a fourth similar instance, which she did not remember exactly.) And lastly, how, when she was twenty-eight and her daughter was very ill, the child had called out to her in her sleep so loudly that she was almost choked. Though these four instances were so widely separated in time, she told me them in a single sentence and in such rapid succession that they might have been a single episode in four acts. Incidentally, all her accounts of [illegible] traumas arranged like these in groups began with a 'how', the component traumas being separated by 'and'. Since I noticed that the protective formula was designed to safeguard her against a recurrence of such experiences, I removed this fear by suggestion, and in fact I never heard the formula from her again.

Evening.—I found her very cheerful. She told me, with a laugh, that she had been frightened by a small dog which barked at her in the garden. Her face was a little drawn, however, and there was some internal agitation which did not disappear until she had asked me whether I was annoyed by something she had said during the massage that morning and I had said no. Her period began again to-day, after an interval of barely a fortnight. I promised to regulate this by hypnotic suggestion and, under hypnosis, set the interval at 28 days.[1]

Under hypnosis, I also asked her whether she remembered the last thing she told me. In asking this what I had in mind was a task which had been left over from yesterday evening; but she began, quite correctly, with the 'don't touch me' from the morning's hypnosis. So I took her back to yesterday's theme. I had asked her the origin of her stammering and she had replied, 'I don't know.'[2] I had therefore requested her to remember it by the time of to-day's hypnosis. She accordingly answered me to-day without any further reflection but in great agitation and with spastic impediments to her speech. 'How

[1] A suggestion which was carried out.

[2] It is possible that this answer, 'I don't know', was correct; but it may quite as well have originated from reluctance to talk about the causes of the stammering. I have since observed in other patients that the greater the [illegible] they have made to repress a thing from their consciousness, the [illegible] they have [illegible] under hypnosis as well as in waking life.

[illegible]

[illegible]

[illegible]

memories had therefore been effective.—Further, [5] how when she was nursing her brother, her aunt's pale face had suddenly appeared over the top of the screen. She had come to convert him to Catholicism.

I saw that I had come to the root of her constant fear of surprises, and I asked her for further instances of this. She went on: How they had a friend staying at her home who liked slipping into the room very softly so that all of a sudden he was there; how she had been so ill after her mother's death and had gone to a health resort and a lunatic had walked into her room several times at night by mistake and come right up to her bed; and lastly, how, on the journey here from Abbazia a strange man had four times opened the door of her compartment suddenly and had fixed his eyes on her each time with a stare. She was so much terrified that she sent for the conductor.

I wiped out all these memories, woke her up and assured her she would sleep well to-night, having omitted to give her this suggestion in her hypnosis. The improvement of her general condition was shown by her remark that she had not done any reading to-day, she was living in such a happy dream—she, who always had to be doing something because of her inner unrest.

May 11, morning.—To-day she had an appointment with Dr. N., the gynaecologist, who is to examine her elder daughter about her menstrual troubles. I found Frau Emmy in a rather disturbed state, though this was expressed in slighter physical signs than formerly. She called out from time to time: 'I'm afraid, so afraid, I think I shall die.' I asked her what she was afraid of: Was it of Dr. N.? She did not know, she said; she was just afraid. Under hypnosis, which I induced before my colleague arrived, she declared that she was afraid she had offended me by something she had said during the massage yesterday which seemed to her to have been impolite. She was frightened of anything new, too, and consequently of the new doctor. I was able to soothe her, and though she started once or twice in the presence of Dr. N., she behaved very well apart from this and produced neither her clacking noises nor any inhibition of speech. After he had gone I put her under hypnosis once more, to remove any possible residue of the excitement

[illegible] She herself was very much pleased with her [illegible] and [illegible] great hopes in the treatment, and I tried to [illegible] her from [illegible] example that there is no need to be afraid of what is new [illegible] what is good.[1]

[illegible] She was very lively and [illegible] of a number [illegible] during our conversation before the [illegible] I asked her what event in her life [illegible] lasting effect on her [illegible] Her [illegible] detail [illegible] with [illegible] deepest [illegible] but without any [illegible] How she began: they had been at a [illegible] were [illegible] and when they were [illegible] a bridge [illegible] the ground and [illegible] for a few [illegible] but had [illegible] got up again and [illegible] well. [illegible] a short time afterwards, as she was [illegible] her [illegible] at breakfast at a [illegible] time [illegible] reading a newspaper [illegible] forward and then [illegible] were [illegible] from the [illegible] was then [illegible] weeks [illegible] had been [illegible] with a [illegible] which had lasted [illegible] months [illegible] she herself had been in bed with a high fever. [illegible] with an angry [illegible] he would speak of [illegible] had been very [illegible] had screamed [illegible] When it was [illegible] had been [illegible] walking [illegible] what [illegible] pointed out to her that this same

[illegible]

[illegible]

too often satisfied with a mere mention.

[illegible] and I did so.[1]

[illegible] town, and so on.

[illegible]

[illegible] comment on her part.

[illegible]

This memory had tormented her a great deal yesterday as well.[1]

The reason for the re-appearance of the clacking was that yesterday she had had abdominal pains and had tried not to show it by groaning. She knew nothing of the true precipitating cause of the clacking (see p. [59]). She remembered, too, that I had instructed her to discover the origin of her gastric pains. She did not know it, however, and asked me to help her. I asked whether, perhaps, on some occasion after a great excitement she had forced herself to eat. She confirmed this. After her husband's death she had for a long time lost her appetite completely and had only eaten from a sense of duty; and her gastric pains had in fact begun at that time. I then removed her gastric pains by stroking her a few times across the epigastrium. She then began of her own accord to talk about the things that had most affected her. 'I have told you', she said, 'that I was not fond of the child. But I ought to add that one could not have guessed it from my behaviour. I did everything that was necessary. Even now I reproach myself for being fonder of the elder one.'

May 14 [*morning*]. — She was well and cheerful and had slept till half-past seven this morning. She only complained of slight pains in the radial region of her hand and in her head and face. What she tells me before the hypnosis becomes more and more significant. To-day she had scarcely anything frightful to produce. She complained of pains and loss of sensation in her right leg. She told me that she had had an attack of abdominal inflammation in 1871; when she had hardly recovered from this she had nursed her sick brother, and it was then that the pains first came on. They had even led to a temporary paralysis of her right leg.

During the hypnosis I asked her whether it would now be

[1] The visual memory of the big lizard had no doubt only attained its great importance owing to its coinciding in time with a powerful affect which she must have experienced during the theatre performance. In treating the present patient, as I have already confessed, I often contented myself and here I was content to accept the most superficial explanations. In this instance, too, I failed to make any further investigation. We shall be reminded, moreover, of hysterical macropsia. Frau Emmy was extremely short-sighted and astigmatic, and her hallucinations may often have been provoked by the indistinctness of her visual perceptions.

[illegible] for her to take part [illegible] she was [illegible] that she had [illegible] danger [illegible] [illegible] she told me of some more occasions on which she had been [illegible] Thus, for instance, when she had been going for a walk with her [illegible] [illegible] she was [illegible] a [illegible] had [illegible] emerged from behind a rock and [illegible] It seems that he was a harmless [illegible] [illegible] [illegible] me, however, that the [illegible] was the persecution to which she had been [illegible] after her husband's death.[1]

[illegible] though she appeared to be in high spirits, she greeted me with the exclamation [illegible] I can [illegible] tell you, I have myself [illegible] that she had had a visit from Dr. [illegible] and [illegible] had [illegible] that it was [illegible] that she should have had to betray [illegible] nervousness. I have more than once [illegible] during these last few days how [illegible] she [illegible] [illegible] the newspaper for me to read [illegible] [illegible] After the removal of [illegible] [illegible] [illegible] I did [illegible] her what [illegible] [illegible] that there is a [illegible] [illegible] between what is good and [illegible] [illegible] take in my [illegible] I [illegible] any [illegible]

[1] At the time I wrote [illegible] I was [illegible] [illegible] as being [illegible] [illegible] (See below, p. [illegible])

the [illegible] who [illegible] the [illegible] of [illegible] f [illegible] the [illegible] [illegible] [illegible] as [illegible]

In her hypnosis she brought up some further [illegible] stories [illegible] the same [illegible] I made her repeat the lessons I had given her while she was awake.

May [illegible] [morning]. She had slept [illegible] but had become [illegible] towards morning and received me with [illegible] [illegible] [illegible] [illegible] and I [illegible] [illegible] was [illegible] [illegible] had [illegible] [illegible] was [illegible] the [illegible] [illegible] [illegible] she asked [illegible] [illegible] an [illegible] [illegible] acquainted with the [illegible] and I know [illegible] the [illegible] property of the owner of the [illegible] to me [illegible] a man who [illegible] of the [illegible] [illegible] [illegible] It seemed to me that we had [illegible] [illegible] [illegible] and [illegible] with [illegible] her [illegible] at [illegible] her [illegible] very [illegible] [illegible] the question to her hypnosis. During massage, which I resumed today after a few days' interval, she told me a [illegible] string of [illegible], which may have been true [illegible] a woman who was shut up in an asylum because she had [illegible] [illegible] [illegible] she was in a [illegible] When she had got these stories out she became very cheerful. She described her [illegible] on her estate and her contacts with prominent men in German Russia and

neurotic woman.

[See below, p. 302 f.]

in such an author

ing any depression to that source

atter factor

least

Evening.—She was in very good spirits and showed a great sense of humour. She told me incidentally that the affair of the [illegible] was not as she had reported it. The proprietor had only said what he did in order to give an excuse for the [illegible] being used for [illegible] purposes. She asked me a great many questions which had nothing pathological about them. She has had distressingly severe pains in her face, in her hand on the thumb side and in her leg. She gets stiff and has pains in her face if she sits without moving or stares at some fixed point for any considerable time. If she lifts anything heavy it brings on pains in her arm.—An examination of her right leg showed fairly good sensibility in her thigh, a high degree of anaesthesia in the lower part of the leg and in the foot and less in the region of the buttock and hip.

In hypnosis she informed me that she still occasionally has frightening ideas, such as that something might happen to her children, that they might fall ill or lose their lives, or that her brother, who is now on his honeymoon, might have an accident, or his wife might die, because the marriages of all her brothers and sisters had been so short. I could not extract any other fears from her. I forbade her any need to be frightened when there was no reason for it. She promised to give it up 'because you ask me to'. I gave her further suggestions for her pains, her leg, etc.

May [illegible] [*morning*].—She had slept well. She still had [illegible] pains in her arms and legs. She was very cheerful. Her [illegible] I applied a faradic brush to her anaesthetic leg.

Evening.—She gave a start as soon as I came in. 'I'm so glad you've come. I am so frightened!' At the same time she gave every indication of terror, together with stammering and tic. I first got her to tell me in her waking state what had happened. Crooking her fingers and stretching out her hands before her, she gave a vivid picture of her terror as she said: 'An enormous mouse suddenly whisked across my hand in the garden and was gone in a flash; things kept on gliding backwards and forwards.' ('An illusion from the play of shadows?') 'A whole lot of mice were sitting in the trees.—Don't you hear the horses stamping in the circus?—There's a man groaning in the next room; he must be in pain after his operation.—Can I be in Rügen? Had I have a stove there like that?' She was

[illegible] by the [illegible] of thoughts crossing one another in [illegible] her [illegible] out her actual surroundings [illegible] them. When I put questions to her about [illegible] such as whether her daughters were here, she could make no answer.

I [illegible] of her mind under hyp[illegible] I asked her what it was that had frightened her. She repeated [illegible] every sign of terror, and added that [illegible] she saw a [illegible] around [illegible] [illegible] were [illegible] [illegible] of [illegible] was [illegible] [illegible]

[illegible]

[illegible] She had a very good [illegible]

took the leeches for worms. I heard this from the nurse. She herself was reluctant to tell me about it. She was almost exaggeratedly cheerful, but she kept interrupting herself with cries of 'Keep still!' and made faces expressive of terror. She also stammered more than she has for the last few days. She told me she had dreamt last night that she was walking on a lot of leeches. The night before she had had horrible dreams. She had had to lay out a number of dead people and put them in coffins, but would not put the lids on. (Obviously, a recollection of her husband.) She told me further that in the course of her life she had had a large number of adventures with animals. The worst had been with a bat which had got caught in her wardrobe, so that she had rushed out of the room without any clothes on. To cure her of this fear her brother had given her a lovely brooch in the shape of a bat; but she had never been able to wear it.

Under hypnosis she explained that her fear of worms came from her having once been given a present of a pretty pincushion; but next morning, when she wanted to use it, a lot of little worms had crept out of it, because it had been filled with bran which was not quite dry. (A hallucination?[1] Perhaps a fact.) I asked her to tell me some more animal stories. Once, she said, when she had been walking with her husband in a park in St. Petersburg, the whole path leading to a pond had been covered with toads, so that they had had to turn back. There had been times when she had been unable to hold out her hand to anyone, for fear of its turning into a dreadful animal, as had so often happened. I tried to free her from her fear of animals by going through them one by one and asking her if she was afraid of them. In the case of some of them she answered 'no'; in the case of others, 'I mustn't be afraid of them.' I asked her why she had stammered and clacked so much. She replied that she always did this when she was very frightened.[2] But why had she been so frightened

[1] The procedure I was following here can scarcely be regarded as a good one: none of it was carried out exhaustively enough.

[2] Her stammering and clacking were not completely cured even after [illegible] the symptom as [illegible] She [illegible] stammering and clacking whenever she

yesterday? Because all kinds of oppressive thoughts had come into her head in the garden: in particular, how she could prevent something from heaping up again inside her after her treatment had come to an end. I repeated the three reasons for feeling reassured which I had already given her: [illegible] that she had become altogether healthier and more capable of resistance, [illegible] that she would get into the habit of telling her thoughts to some one she was on close terms with, and [illegible] she would henceforth regard as indifferent a whole number of things which had hitherto weighed upon her. She went on to say that she had been worried as well because she had not thanked me for my visiting her late in the day, and she was afraid that I would lose patience with her on account of her recent relapse. She had been very much upset and alarmed because the house physician had asked a gentleman in the garden whether he was now able to face his operation. His wife had been sitting beside him, and she, the patient, could not help thinking [illegible] be the poor man's last evening. [illegible] her depression seemed to be cleared up.

Evening.—She was very cheerful, and [illegible] the happiness [illegible] whatever I desired [illegible] particular pains and [illegible] restoring [illegible] [illegible] was very easily [illegible] but her restored [illegible] was [illegible] lost again when she woke [illegible] before I left her she expressed her astonishment that it was such a long time since she had had any neck [illegible] though they [illegible] come on before every change [illegible]

May 9.—She had slept last night better than she had for years. But after her bath she complained [illegible] at the back of her [illegible]

was [illegible] that in the end these symptoms [illegible] to be [illegible]

It was here that I learnt for the first time [illegible] when [illegible] a reverse [illegible] [illegible] The same [illegible]

[illegible] the face, hands and feet. Her [illegible] and her [illegible] [illegible]

I [illegible] from the history of the first three weeks of [illegible] character of [illegible] I shall now proceed to amplify the case history.

[illegible] whom I have last described was [illegible]

[illegible]

[illegible] her maxims which were to remain constantly present to her mind and to protect her from relapsing into similar conditions when she had got home. At that time I was completely under the sway of Bernheim's book on suggestion,¹ and I anticipated more results from such educative measures than I should to-day. My patient's condition improved so rapidly that she soon assured me she had not felt so well since her husband's death. After a treatment lasting in all for seven weeks I allowed her to return to her home on the Baltic.

It was not I but Dr. Breuer who received news of her about seven months later. Her health had continued good for several months but had then broken down again as a result of a fresh psychical shock. Her elder daughter, during their first stay in Vienna, had already followed her mother in developing stomach cramps and mild hysterical states; but in particular she had suffered from pain in walking owing to a retroverted uterus. On my advice she had gone for treatment to Dr. N., one of our most distinguished gynaecologists, who had put her uterus right by massage, and she had remained free from her troubles for several months. Her trouble recurred, however, while they were at home, and her mother called in a gynaecologist from the neighbouring University town. He prescribed a combined local and general treatment for the girl, which, however, brought on a severe nervous illness. She was seventeen at the time. It is probable that this was already an indication of her pathological disposition which was to manifest itself a year later in a character-change (see below, p. …). Her mother, who had handed the girl over to the doctors with her usual mixture of docility and mistrust, was overcome by the most violent self-reproaches after the unfortunate outcome of the treatment. A train of thought which I have not gone into brought her to the conclusion that Dr. N. and I were together responsible for the girl's illness because we had made light of her serious condition. By an act of will, as it were, she undid the effects of my treatment and promptly relapsed into the states from which I had freed her. A distinguished physician in her neighbourhood, to whom she went for advice, and Dr. Breuer, who was in correspondence with her, succeeded

¹ [Freud himself translated this book (Bernheim, 1886) and the translation was published in 1888–9.]

in convincing her of the innocence of the two targets of her accusations; but even after this was cleared up, the aversion to me which she formed at the time was left over as a hysterical residue, and she declared that it was impossible for her to take up her treatment with me again. On the advice of the same medical authority she turned for help to a Sanatorium in North Germany. At Breuer's desire I explained to the physician in charge the modification of hypnotic therapy which I had found effective in her case.

This attempted transfer[1] failed completely. From the very first she seems to have been at cross purposes with the doctor. She exhausted herself in resisting whatever was done for her. She went downhill, lost sleep and appetite, and only recovered after a woman friend of hers who was visiting her in the Sanatorium in effect secretly abducted her and looked after her in her house. A short time afterwards, exactly a year after her first meeting with me, she was again in Vienna and put herself once more into my hands.

I found her much better than I had expected from the accounts I had received by letter. She could get about and was free from anxiety; much of what I had accomplished the year before was still maintained. Her chief complaint was of frequent states of confusion—'storms in her head' as she called them. Besides this she suffered from sleeplessness, and was often in tears for hours at a time. She felt sad at one particular time of day—five o'clock. This was the regular hour at which, during the winter, she had been able to visit her daughter in the nursing home. She stammered and clacked a great deal and kept rubbing her hands together as though she was in a rage, and when I asked her if she saw a great many animals, she only replied: 'Oh, keep still!'

At my first attempt to induce hypnosis she clenched her fists and exclaimed: 'I won't be given any antipyrin injections; I would rather have my pains! I don't like Dr. K.; he is antipathetic to me.' I perceived that she was involved in the memory of being hypnotized in the sanatorium, and she calmed down as soon as I brought her back to the present situation.

At the very beginning of the [resumed] treatment I had an

[1] [Though the German word here is 'Übertragung', it is evidently not used in the technical sense of 'transference' which is first found at the end of this volume, on p. 302.]

instructive experience. I had asked her how it was that she had had a recurrence of the stammering, and she answered (under hypnosis) that it was ever since a fright she had at D— during the winter. A waiter at the hotel in which she was staying had hidden himself in her room. In the darkness she said she had taken the thing for an overcoat and put out her hand to take hold of it; and the man had suddenly 'shot up'. I took this memory-picture away, and in fact from that time on she ceased to stammer noticeably either in hypnosis or in waking life. I cannot remember what it was that led me to test the success of my suggestion. But when I returned the same evening I asked her in an apparently innocent way how I could manage to fasten the door when I went away while she was lying asleep so that no one could slip into the room. To my astonishment she gave a violent start and began grinding her teeth and rubbing her hands. She indicated that she had had a severe shock of that kind at D— but could not be persuaded to tell me the story. I observed that she had in mind the same story which she had told me that morning during the hypnosis and which I thought I had wiped out. In her next hypnosis she told me the story in greater detail and more truthfully. In her excitement she had been walking up and down the passage and found the door of her maid's room open. She had tried to go in and sit down. Her maid had stood in the way, but she would not be stopped and walked in, and then noticed a dark form against the wall which turned out to be a man. It was evidently the erotic element in this little adventure which had caused her to give an untrue account of it. [illegible] incomplete story under hypnosis produces no therapeutic effect. I accustomed myself to regarding as incomplete any story that brought about no improvement, and I gradually came to be able to see from patients' faces whether they might not be concealing an essential part of their confessions.

The work that I had to do with her [illegible] getting in hypnosis [illegible]. In the disagreeable [illegible] she had received during her daughter's treatment and [illegible] was in the [illegible]. She was [illegible] the [illegible] who had compared her [illegible] but the word '[illegible]' [illegible] never to make her say it. In this connection I ventured upon a

overcharged with urates.

practice to make use of this suggestion over her. It was the only piece of hypnosis—and a fairly innocent one at that—which I have to plead guilty with this patient. I assured her that her stay in the sanatorium at *Ab*—, [illegible] made to her that she would not even be able to recall its name and that whenever she wanted to refer to it she would hesitate between '*Berg*...' ['mountain'], '*Tal*...' ['valley'], '*Wald*...' ['wood'] and so on. This duly happened and presently the only remaining sign of her speech inhibition was her uncertainty over this name. Eventually, following a remark by Dr. Breuer, I relieved her of this compulsive paramnesia.

I had a longer struggle with what she described as 'the storms in her head' than with the residues of these experiences. When I first saw her in one of these storms she was lying on the sofa with her features distorted and her whole body in ceaseless restlessness. She kept on pressing her hands to her forehead and calling out in yearning and helpless tones the name 'Emmy', which was her elder daughter's as well as her own. Under hypnosis she informed me that this state was a repetition of the many fits of despair by which she had been overcome during her daughter's treatment, when, after she had spent hours in trying to discover some means of correcting its bad results, no way out presented itself. When, at such a time, she felt her thoughts becoming confused, she made it a practice to call out her daughter's name, so that it might help her back to clear-headedness. For, during the period when her daughter's [illegible] was imposing fresh duties on her and she felt that her own nervousness was once again gaining a hold over her, she had determined that whatever had to do with the girl must be kept free from confusion, however chaotic everything else in her head was.

In the course of a few weeks we were able to dispose of these memories too, and Frau Emmy remained under my observation for some time longer, feeling perfectly well. At the very end of her stay something happened which I shall describe in detail, since it throws the strongest light on the patient's character and the manner in which her states came about.

I called on her one day at lunch-time and surprised her in the act of throwing something wrapped up in paper into the garden, where it was caught by the children of the house-porter. In reply to my question she admitted that it was her

[illegible]

'Why can't you eat more?'

[illegible]

had spent some months in Munich and almost all of them had contracted gastric catarrh owing to the bad drinking water. In the case of the others the trouble was quickly relieved by medical treatment; but with her it had persisted. Nor had she been improved by the mineral water which she was recommended. When the doctor had prescribed it she had thought at once: 'That won't be any use.' From that time onwards this intolerance of natural and mineral waters had recurred on countless occasions.

The therapeutic effect of these discoveries of mine was immediate and lasting. She did not starve herself for a week, but the very next day she ate and drank without making any difficulty. Two months later she wrote in a letter: 'I am eating excellently and have put on a great deal of weight. I have drunk forty bottles of the water. Should I go on with it?'

I saw Frau von N. again in the spring of the following year at her estate near D——. At this time her elder daughter, whose name she had called out during her 'storms in the head', was entering on a phase of abnormal development. She exhibited ambitions which were out of all proportion to the poverty of her gifts, and she became disobedient and even violent towards her mother. I still enjoyed her mother's confidence and was sent for to give my opinion on the girl's condition. I formed an unfavourable impression of the psychological change that had occurred in the girl, and in arriving at a prognosis I had also to take into account the fact that her step-brothers and sisters (Herr von N.'s children by his first marriage) had succumbed to paranoia. In her mother's family, too, there was no lack of a neuropathic heredity, although none of her more immediate relatives had developed a chronic psychosis. I communicated to Frau von N. without any reservation the opinion for which she had asked and she received it calmly and with understanding. She had grown stout, and looked in flourishing health. She had felt relatively very well during the nine months that had passed since the end of her last treatment. She had only been disturbed by slight neck-cramps and other minor ailments. During the several days which I spent in her house I came for the first time to realize the whole extent of her duties, occupations and intellectual interests. I also met the family doctor, who had not many

[illegible] come to terms with the profession. [illegible]

[illegible] journey to Vienna.

[illegible]

words written on it.' This was in the morning. A few hours later the little episode took place exactly as I had pre-arranged it and so naturally that none of the many people present noticed anything. When she asked me for the wine she showed visible signs of an internal struggle—for she never drank wine—and after she had refused the drink with obvious relief, she put her hand into her bag and drew out the piece of paper on which appeared the last words she had spoken. She shook her head and stared at me in astonishment.

After my visit in May, 1890, my news of Frau von N. became gradually scantier. I heard indirectly that her daughter's deplorable condition, which caused her every kind of distress and agitation, did eventually undermine her health. Finally, in the summer of 1893, I had a short note from her asking my permission for her to be hypnotized by another doctor, since she was ill again and could not come to Vienna. At first I did not understand why my permission was necessary, till I remembered that in 1890 I had, at her own request, protected her against being hypnotized by anyone else, so that there should be no danger of her being distressed by coming under the control of a doctor who was antipathetic to her, as had happened at *—berg* (*—tal*, *—wald*). I accordingly renounced my exclusive prerogative in writing.

Discussion

Unless we have first come to a complete agreement upon the terminology involved, it is not easy to decide whether a particular case is to be reckoned as a hysteria or some other neurosis (I am speaking here of neuroses which are not of a purely neurasthenic type); and we have still to await the directing hand which shall set up boundary-marks in the region of the commonly occurring mixed neuroses and which shall bring out the features essential for their characterization. If, accordingly, we are still accustomed to diagnosing a hysteria, in the narrower sense of the term, from its similarity to familiar typical cases, we shall scarcely be able to dispute the fact that the case of Frau Emmy von N. was one of hysteria. The mildness of her deliria and hallucinations (while her other mental activities remained intact), the change in her personality and store of memories when she was in a state of artificial somnambulism,

the [illegible] in her painful leg, certain data [illegible] in her [illegible] her [illegible] treatment [illegible], admit of [illegible] as [illegible] of the [illegible], or at least of the patient [illegible] can be [illegible] at [illegible] of the case [illegible] provides an [illegible] that is of general validity. As we have [illegible] in the [illegible] which appears at the beginning of this volume, we regard [illegible] symptoms as [illegible] of excitations [illegible] are not [illegible] has been discharged by [illegible]. It is [illegible] any longer at [illegible]. We must regard the [illegible] as [illegible] system is [illegible] so far as it has not been [illegible]. Now we are [illegible] that a [illegible] part of [illegible] of the [illegible]. It is [illegible] of hysteria which [illegible] the way of its being [illegible] as a psychical disorder.

If, for the sake of brevity, we adopt the term [illegible] we may say that in the case of Fräulein [illegible] a small amount of conversion. The excitation which was [illegible] remained for the most part in the [illegible]; it is easy to see that this gives a [illegible]. There are cases of hysteria in which the whole [illegible] undergoes conversion, [illegible] of hysteria [illegible] in what [illegible] normal [illegible]. An [illegible] is however more usual, so that some part at

[illegible] a few months after the present [illegible] expressed these views [illegible]

[illegible] term in his first paper on the [illegible] See however [illegible]

least of the affect that accompanied the trauma persists on, as a component of the patient's state of feeling.

The psychical symptoms in the present case of hysteria with very little conversion can be divided into alterations of mood (anxiety, melancholic depression), phobias and abulias (inhibitions of will). The two latter classes of psychical disturbance are regarded by the French school of psychiatrists as stigmata of nervous degeneracy, but in our case they are seen to have been adequately determined by traumatic experiences. These phobias and abulias were for the most part of traumatic origin, as I shall show in detail.

Some of the phobias, it is true, corresponded to the primary phobias of human beings, and especially of neuropaths—in particular, for instance, her fear of animals (snakes and toads, as well as all the vermin of which Mephistopheles boasted himself master[1]), and of thunderstorms and so on. But these phobias too were established more firmly by traumatic events. Thus her fear of toads was strengthened by her experience in early childhood of having a dead toad thrown at her by one of her brothers, which led to her first attack of hysterical spasms (p. 55), and similarly her fear of thunderstorms was brought out by the shock which gave rise to her clacking (p. 58), and her fear of fogs by her walk on the Island of Rügen (p. 68). Nevertheless, in this group the primary—or one might say the instinctive—fear, regarded as a psychical stigma, plays the preponderant part.

The other, more specific phobias were also accounted for by particular events. Her dread of unexpected and sudden shocks was the consequence of the terrible impression made on her by seeing her husband, when he seemed to be in the best of health, succumb to a heart attack before her eyes. Her dread of strangers, and of people in general, turned out to be derived from the time when she was being persecuted by her husband's family and was inclined to see one of their agents in every stranger and when it seemed to her likely that strangers knew of the things that were being spread abroad about her in writing and by word of mouth (p. 64). Her fear of asylums and their inmates went back to a whole series of unhappy events

[1] [The lord of rats and eke of mice,
Of flies and bed-bugs, frogs and lice.
Goethe, *Faust*, Part I, Scene 3. Bayard Taylor's translation.]

in her earlier years and to stories poured into her listening ears by a [illegible]. Apart from that, this phobia was [illegible] by the primary and [illegible] felt by healthy people, and on the other hand by the fear felt by her no less than by all neurotics, of going [illegible]. Her highly specific fear that someone was standing behind her, [illegible], was determined by a number of terrifying experiences in her youth and later life. Since the episode in the hotel, which was especially distressing to her because [illegible] her fear of a stranger creeping into her room was greatly intensified. Finally, her fear of being buried alive, which she shared with so many neuropaths, was entirely explained by her belief that her husband was not dead when his body was carried out—a belief which gave such moving expression to her inability to accept the fact that her life with the man she loved had come to a sudden end. In my opinion, however, all these psychical[1] factors, though they may account for the choice of these phobias, cannot explain their persistence. It is necessary, I think, to adduce a neurotic factor to account for this persistence—the fact that the patient had been living for years in a state of sexual abstinence. Such circumstances are among the most frequent causes of a tendency to anxiety.[2]

Our patient's abulias (inhibitions of will, inability to act) admit even less than her phobias of being regarded as psychical symptoms due to a general limitation of capacity. On the contrary, the hypnotic analysis of the case made it clear that her abulias were conditioned by a twofold psychical mechanism which was at bottom a single one. In the first place an abulia may simply be the consequence of a phobia. This is so when the phobia is attached to an action of the subject's own instead of to an expectation [of an external event]—for instance, in our present case, the fear of going out or of mixing with people, as compared with the fear of someone creeping into the room. Here the inhibition of will is caused by the anxiety attendant

[1] [In the first German edition only, this word reads 'physical', which was clearly a misprint.]

[2] [illegible] 'actual-neuroses'.]

upon the performance of the action. It would be wrong to regard abulias of this kind as symptoms distinct from the corresponding [illegible] it must be admitted that such [illegible] are not [illegible] severe [illegible]. The second class of abulias depends on the presence of affectively-toned and unresolved associations which are opposed to linking up with other associations and particularly with any that are incompatible with them. Our patient's anorexia offers a most brilliant instance of this kind of abulia [illegible]. She ate so little because she did not like the taste, and she could not enjoy the taste because the act of eating had from the earliest times been connected with memories of disgust whose sum of affect had never been to any degree diminished; and it is impossible to eat with disgust and pleasure at the same time. Her old-established disgust at meal-times had persisted undiminished because she was obliged all the time to suppress it, instead of getting rid of it by reaction. In her childhood she had been forced, under threat of punishment, to eat the cold meal that disgusted her, and in her later years she had been prevented out of consideration for her brothers from expressing the affects to which she was exposed during their meals together.

At this point I may perhaps refer to a short paper in which I have tried to give a psychological explanation of hysterical paralyses [illegible]. I there arrived at a hypothesis that the cause of these paralyses lay in the inaccessibility to fresh associations of a group of ideas connected, let us say, with one of the extremities of the body; this associative inaccessibility depended in turn on the fact that the idea of the paralysed limb was involved in the recollection of the trauma—a recollection loaded with affect that had not been disposed of. I showed from examples from ordinary life that a cathexis such as this of an idea whose affect is unresolved always involves a certain amount of associative inaccessibility and of incompatibility with new cathexes.

I have not hitherto succeeded in confirming by means of [illegible] this theory about motor paralyses, but I [illegible]

[illegible] This seems [illegible] first published appearance of [illegible] in the special sense in which [illegible]

[illegible]

[illegible] ism of the somatic symptoms.

[illegible]

[illegible] *Five Lectures* (1910*a*).]

[illegible] phobia which played such a large part in the patient's life. These [illegible] may well have been [illegible] on [illegible] grounds, but had since then been [illegible] I base these assertions about Frau von N.'s [illegible] made elsewhere which I [illegible] on a later page. [illegible] be gathered from the patient herself.[1]

Some of the striking motor phenomena exhibited by Frau von N. were simply an expression of the emotions and could easily be recognized in that light. Thus, the way in which she stretched her hands in front of her with her fingers spread out and crooked expressed horror, and similarly her facial play. This, of course, was a more lively and uninhibited way of expressing her emotions than was usual with women of her education and race. Indeed, she herself was restrained, almost stiff in her expressive movements when she was not in a hysterical state. Others of her motor symptoms were, according to herself, directly related to her pains. She played restlessly with her fingers [illegible] or rubbed her hands against one another [illegible] so as to prevent herself from screaming. This reason reminds one forcibly of one of the principles laid down by Darwin to explain the expression of the emotions—the principle of the overflow of excitation [Darwin, 1872, Chapter III], which accounts, for instance, for dogs wagging their tails. We are all of us accustomed, when we are affected by painful stimuli, to replace screaming by other sorts of motor innervations. A person who has made up his mind at the dentist's to keep his head and mouth still and not to put his hand in the way, may at least start drumming with his feet.[2]

A more complicated method of conversion is revealed by Frau von N.'s tic-like movements, such as clacking with the tongue and stammering, calling out the name 'Emmy' in attacks of confusion, using the composite formula 'Keep still!—Don't say anything!—Don't touch me!' [illegible]. Of these motor manifestations, the stammering and clacking can be explained in accordance with a mechanism which I have described in a short paper on the treatment of a case by

1 [illegible] p. 174. See also above, p. 71 n.]

2 [illegible] Breuer's remarks on the same subject, [illegible]

hypnotic suggestion (1892–3b)] as the putting into effect of antithetic ideas.[1] The process, as exemplified in our present instance [p. 54], would be as follows. Our hysterical patient, exhausted by worry and long hours of watching by the bedside of her sick child which had at last fallen asleep, said to herself: 'Now you must be perfectly still so as not to awaken the child.' This intention probably gave rise to an antithetic idea in the form of a fear that she might make a noise all the same that would wake the child from the sleep which she had so long hoped for. Similar antithetic ideas arise in us in a marked manner when we feel uncertain whether we can carry out some important intention.

Neurotics, in whose self-feeling we seldom fail to find a strain of depression or anxious expectation, form greater numbers of these antithetic ideas than normal people, or perceive them more easily, and they regard them as of more importance. In our patient's state of exhaustion the antithetic idea, which was normally rejected, proved itself the stronger. It is this idea which put itself into effect and which, to the patient's horror, actually produced the noise she dreaded. In order to explain the whole process it may further be assumed that her exhaustion was only a partial one; it affected, to use the terminology of Janet and his followers, only her 'primary ego' and did not result in a weakening of the antithetic idea as well.

It may further be assumed that it was her horror at the noise produced against her will that made the moment a traumatic one, and fixed the noise itself as a somatic mnemic symbol[2] of the whole scene. I believe, indeed, that the character of the tic itself, consisting as it did of a succession of sounds which were convulsively emitted and separated by pauses and which could be best likened to clackings, reveals traces of the process to which it owed its origin. It appears that a conflict had occurred between her intention and the antithetic idea (the counter-will) and that this gave the tic its discontinuous character and confined the antithetic idea to paths other than

[1] [The concept of antithetic ideas, as well as that of 'counter-will' which is dependent on it (see below), was discussed in that same paper.]

[2] [In [illegible] German [illegible] 'Symptom' seems preferable [illegible] 'Symbol'. 'Symbol', however, appears to give the better sense and has been used throughout the book. See footnote p. [illegible].]

the habitual ones for innervating the muscular apparatus of speech.

The patient's spasmodic inhibition of speech, her peculiar stammer, was the product of an exactly similar determining cause [illegible]. Here, however, it was not the outcome of the final innervation but the process of innervation itself, the attempted interruption of the organs of speech, which was made into a symbol of the event for her memory.

These two symptoms, the clacking and the stammering, which were thus closely related through the history of their origin, continued to be associated and were turned into chronic symptoms after being repeated on a similar occasion. Thereafter they were put to a further use. Having originated at a moment of violent fright, they were thenceforward joined to any fright [illegible] in accordance with the mechanism of monosymptomatic hysteria which will be described in Case 5 [illegible], even when the fright could not lead to an antithetic idea being put into effect.

The two symptoms were eventually linked up with so many traumas, had so much reason for being reproduced in memory, that they perpetually interrupted the patient's speech for no particular cause, in the manner of a meaningless tic. Hypnotic analysis, however, was able to demonstrate how much meaning lay concealed behind this apparent tic; and if the Breuer procedure did not succeed in this case in getting rid of the two symptoms completely at a single blow, that was because the catharsis had extended only to the three principal traumas and not to the secondarily associated ones.[1]

Scarcely any references to [illegible] in Freud's later [illegible]. In a paper on the subject Ferenczi [illegible] I had [illegible] a question on the meaning of [illegible] suggested that [illegible] with [illegible].]

[1] I may here be giving an impression of laying too much emphasis on the details of the symptoms and of becoming lost in an unnecessary maze of sign-reading. But I have come to learn that the determination of hysterical symptoms does in fact extend to their subtlest manifestations and that it is difficult to attribute too much sense to them. Let me give an example to justify this statement. Some months ago I had under my treatment a girl of eighteen years of age belonging to a family with a [illegible] heredity. Hysteria played its part in her complicated neurosis. The first thing I heard from her was a complaint that she suffered from attacks of despair of two varieties. In one variety she [illegible] and

[illegible]

of thought.

[illegible]

turned into a dementia praecox.

gave her. The two states were separated in her memory, and she would sometimes be highly astonished to hear of the things which the dream had introduced piecemeal into her normal consciousness. My very first interview with her was the most striking instance of the way in which the two states were interwoven without paying any attention to each other. Only at one moment of this psychical see-sawing did it happen that her normal consciousness, in touch with the present day, was affected. This was when she gave me an answer which originated from her dream and said she was 'a woman dating from last century' [p. 52 n.].

The investigation of these states of hypnosis in Frau von N. was not exhaustively carried out. This was mainly because her condition improved so rapidly that her deliria became sharply distinguished from her normal life and were restricted to the periods of her neck-cramps. On the other hand I gathered a great deal of information about the patient's behaviour in a third state, that of artificial somnambulism. Whereas in her normal state she had no knowledge of what she had experienced during her deliria and during her somnambulism, she had access during somnambulism to the memories of all three states. In point of fact, therefore, she was at her most normal in somnambulism. Indeed, if I leave on one side the fact that in somnambulism she was far less reserved with me than she was at her best moments in ordinary life—that is, that in somnambulism she gave me information about her family and such things, whereas at other hours she treated me as a stranger—and if, further, I disregard the fact that she exhibited the full degree of suggestibility characteristic of somnambulism, I am bound to say that during her somnambulism she was in a completely normal state. It was interesting to notice that on the other hand her somnambulism showed no trace of being supernormal, but was subject to all the mental failings that we are accustomed to associate with a normal state of consciousness.

An example which follows throws light on the behaviour of her memory in somnambulism. In conversation one day she expressed her delight at the beauty of a plant in a pot which ornamented the entrance-hall of the nursing-home. 'But what is its name, Doctor? Do you know? I used to know its German and its Latin names, but I've forgotten them both.' She had a wide

[illegible]

[illegible] never failed to occur.

[illegible]

her [illegible] as a [illegible] [illegible] [illegible] a large [illegible] great [illegible] the efforts of 'degenerates'.

[illegible]

[illegible] Janet's '*insuffisance psychologique*'.]

[illegible]

[illegible]

stance of the 'compulsion to repeat'.

[illegible]

married.

[illegible]

CASE 3

Miss Lucy R., age 30 (Freud)

[illegible] appetite and loss of efficiency.

[illegible]

[illegible]

which the recurring sensations of smell symbolized in memory. It might be more correct to regard the recurrent olfactory hallucinations, together with the depression which accompanied them, as equivalents of a hysterical attack. The nature of recurrent hallucinations makes them unsuitable to play the part of chronic symptoms. But this question did not really arise in a case like this which showed only a rudimentary development. It was essential, however, that the subjective sensations of smell should have had a specialized origin of a sort which would admit of their being derived from some quite particular real object.

This expectation was promptly fulfilled. When I asked her what the smell was which troubled her most, she answered: 'A smell of burnt pudding.' Thus I only needed to assume that a smell of burnt pudding had actually occurred in the experience which had operated as a trauma. It is very unusual, no doubt, for olfactory sensations to be chosen as mnemic symbols of traumas, but it was not difficult to account for this choice. The patient was suffering from suppurative rhinitis and consequently her attention was especially focused on her nose and nasal sensations. What I knew of the circumstances of the patient's life was limited to the fact that the two children whom she was looking after had no mother; she had died some years earlier of an acute illness.

I therefore decided to make the smell of burnt pudding the starting-point of the analysis. I will describe the course of this analysis as it might have taken place under favourable conditions. In fact, what should have been a single session spread over several. This was because the patient could only visit me in my consulting hours, when I could only devote a short time to her. Moreover, a single discussion of this sort used to extend over more than a week, since her duties would not allow her to make the long journey from the factory to my house very often. We used therefore to break off our conversation short and take up the thread at the same place next time.

Miss Lucy R. did not fall into a state of somnambulism when I tried to hypnotize her. I therefore did without somnambulism and conducted her whole analysis while she was in a state which may in fact have differed very little from a normal one.

I shall have to go into this point of my technique in greater

[illegible] I visited the [illegible] [illegible] the [illegible] of hypnotism, [illegible] the means of [illegible] every patient into a state [illegible] therapy would be the most powerful of [illegible] it almost seemed as though [illegible] [illegible] as soon as I tried to practise this art on my own patients, I discovered that my powers at least were [illegible] and that if [illegible] were not [illegible] at the first three attempts I had no [illegible]. The percentage of cases [illegible] was very much lower in my experience than what Bernheim reported.

[illegible]

[illegible]

that provided me the precise result that I needed. And I can safely say that it has scarcely ever left me in the lurch since then; it has always pointed the way which the analysis should take and has enabled me to carry through every such analysis to an end without the use of somnambulism. I gradually grew so confident that, if patients answered 'I see nothing' or 'nothing occurred to me', I could dismiss this as an impossibility and could assure them that they had certainly become aware of what was wanted but had refused to believe that that was so and had rejected it. I told them I was ready to repeat the procedure as often as they liked and they would see the same thing every time. I turned out to be invariably right. The patients had not yet learned to relax their critical faculty. They had rejected the memory that had come up or the idea that had occurred to them, on the ground that it was unserviceable and an irrelevant interruption; and after they had told it to me it always proved to be what was wanted. Occasionally, when, after three or four pressures, I had at last extracted the information, the patient would reply: 'As a matter of fact I knew that the first time, but it was just what I didn't want to say', or: 'I hoped that would not be it.'

This business of enlarging what was supposed to be a restricted consciousness was laborious—far more so, at least, than an investigation during somnambulism. But it nevertheless made me independent of somnambulism, and gave me insight into the motives which often determine the 'forgetting' of memories. I can affirm that this forgetting is often intentional and desired; and its success is never more than *apparent*.

I found it even more surprising perhaps that it was possible by the same procedure to bring back numbers and dates which, on the face of it, had long since been forgotten, and so to reveal how unexpectedly accurate memory can be.

The fact that in looking for numbers and dates our choice is so limited enables us to call to our help a proposition familiar

few weeks I have taken up hypnotism again. [illegible] a lecture given before the Vienna College of Physicians [illegible] on December [illegible] Freud [illegible] Standard Ed., 7, [illegible] the remark: 'I have not used [illegible] for therapeutic purposes for many years, except for a few special experiments [illegible] approximately between the years 1887 and 1896.]

to us from the theory of aphasia, namely that [illegible]

[illegible]

able to call them to mind.[4]

[illegible]

[illegible]

[illegible]

[illegible] which you did not want to think of?'

[illegible]

[illegible] thing fitted together

were so affectionate to me.' 'Weren't they always?' 'Yes, but most when I got the letter from my mother.' 'I don't understand why there is a contrast between the children's affection and your mother's letter; for that's what you seem to be suggesting.' 'I was intending to go back to my mother's, and the thought of leaving the dear children made me feel so sad.' 'What's wrong with your mother? Has she been living alone and sent for you? Or was she ill at the time, and were you expecting news of her?' 'No; she isn't very strong, but she's not exactly ill, and she has a companion with her.' 'Then why must you leave the children?' 'I couldn't bear it any longer in the house. The housekeeper, the cook and the French governess seem to have thought that I was putting myself above my station. They joined in a little intrigue against me and said all sorts of things against me to the children's grandfather, and I didn't get as much support as I had expected from the two gentlemen when I complained to them. So I gave notice to the Director (the children's father). He answered in a very friendly way that I had better think the matter over for a couple of weeks before I finally gave him my decision. I was in this state of uncertainty at the time, and thought I should be leaving the house; but I have stayed on.' 'Was there something particular, apart from their fondness for you, which attached you to the children?' 'Yes. Their mother was a distant relation of my mother's, and I had promised her on her death-bed that I would devote myself with all my power to the children, that I would not leave them and that I would take their mother's place with them. In giving notice I had broken this promise.'

This seemed to complete the analysis of the patient's subjective sensation of smell. It had turned out in fact to have been an objective sensation originally, and one which was intimately associated with an experience—a little scene—in which opposing affects had been in conflict with each other: her regret at abandoning the children and the slights which were nevertheless urging her to make up her mind to do so. Her mother's letter had not unnaturally reminded her of her reasons for this decision, since it was her intention to join her mother on leaving here. The conflict between her affects had elevated the moment of the letter's arrival into a trauma, and the sensation of smell that was associated with this trauma persisted as its

[illegible]

[illegible]

had acquired hysteria.

[illegible]

[illegible]

[1] [See footnote p. 10.]

been one which she had sought [illegible] to leave in obscurity and had made efforts to forget. If her fondness for the children and her sensitiveness on the subject of the other members of the household were taken together, only one conclusion could be reached. I was bold enough to inform my patient of this interpretation. I said to her: 'I cannot think that these are all the reasons for your feelings about the children. I believe that really you are in love with your employer, the Director, though perhaps without being aware of it yourself, and that you have a secret hope of taking their mother's place in actual fact. And then we must remember the sensitiveness you now feel towards the servants, after having lived with them peacefully for years. You're afraid of their having some inkling of your hopes and making fun of you.'

She answered in her usual laconic fashion: 'Yes, I think that's true.'—'But if you knew you loved your employer why didn't you tell me?'—'I didn't know—or rather I didn't want to know. I wanted to drive it out of my head and not think of it again; and I believe latterly I have succeeded.'[1]—'Why was it that you were unwilling to admit this inclination? Were you ashamed of loving a man?'—'Oh no, I'm not unreasonably prudish. We're not responsible for our feelings, anyhow. It was distressing to me only because he is my employer and I am in his service and live in his house. I don't feel the same complete independence towards him that I could towards anyone else. And then I am only a poor girl and he is such a rich man of good family. People would laugh at me if they had any idea of it.'

[1] I have never managed to give a better description than this of the strange state of mind in which one knows and does not know a thing at the same time. It is clearly impossible to understand it unless one has been in such a state oneself. I myself have had a very remarkable experience of this sort, which is still clearly before me. If I try to recollect what went on in my mind at the time I can get hold of very little. What happened was that I saw something which did not fit in at all with my expectation; yet I did not allow what I saw to disturb my fixed plan in the least, though the perception should have put a stop to it. I was unconscious of any contradiction in this; nor was I aware of my feelings of repulsion, which must nevertheless undoubtedly have been responsible for the perception producing no psychical effect. I was afflicted by that blindness of the seeing eye which is so astonishing in the attitudes of mothers to their daughters, husbands to their wives and rulers to their favourites.

She now showed no resistance to [illegible] the origin of this inclination. She told me that for the last few years she had lived happily in the house, carrying out her duties and free from any unfulfilled wishes. One day, however, her employer, a serious, overworked man whose behaviour towards her had always been reserved, began a discussion with her on the lines along which children should be brought up. He unbent more and was more cordial than usual and told her how much he depended on her for looking after his orphaned children; and as he said this he looked at her meaningly.... Her love for him had begun at that moment, and she even allowed herself to dwell on the gratifying hopes which she had based on this talk. But when there was no further development, and when she had waited in vain for a second hour's intimate exchange of views, she decided to banish the whole business from her mind. She entirely agreed with me that the look which she had caught during their conversation had probably sprung from his thoughts about his wife, and she recognized quite clearly that there was no prospect of her feelings meeting with any return.

I expected that this discussion would bring about a fundamental change in her condition. But for the time being it did not occur. She continued to be in low spirits and depressed. She felt somewhat refreshed in the mornings by a course of hydropathic treatment which I prescribed for her at the same time. The smell of burnt pudding did not disappear completely, though it became less frequent and weaker. It only came on, she said, when she was very much agitated. The persistence of this mnemic symbol led me to suspect that, in addition to the main scene, it had taken over the representation of the many minor traumas subsidiary to that scene. We therefore looked about for anything else that might have to do with the scene of the burnt pudding; we went into the subject of domestic friction, the grandfather's behaviour, and so on, and as we did so the burning smell faded more and more. During this time, too, the treatment was interrupted for a considerable while, owing to a fresh attack of her nasal disorder, and this now led to the discovery of the [illegible]

On her return she reported that at Christmas she had received a great many presents from the two gentlemen of the house and even from the servants, as though they were all

anxious to make it up with her and to wipe out her memory of the events of the last few months. But these signs of goodwill had not made any impression on her.

When I enquired once more about the smell of burnt pudding, I found that it had quite disappeared but that she was being bothered by another, similar smell, resembling cigar smoke. It had been there earlier as well, she thought, but had, as it were, been covered by the smell of the pudding. Now it had emerged by itself.

I was not very well satisfied with the results of the treatment. What had happened was precisely what is always brought up against purely symptomatic treatment: I had removed one symptom only for its place to be taken by another. Nevertheless, I did not hesitate to set about the task of getting rid of this new mnemic symbol by analysis.

But this time she did not know where the subjective olfactory sensation came from—on what important occasion it had been an objective one. 'People smoke every day in our house,' she said, 'and I really don't know whether the smell I notice refers to some special occasion.' I then insisted that she should try to remember under the pressure of my hand. I have already mentioned that her memories had the quality of plastic vividness, that she was a 'visual' type. And in fact, at my insistence a picture gradually emerged before her, hesitatingly and piecemeal to begin with. It was the dining-room in her house, where she was waiting with the children for the two gentlemen to return from the factory for lunch. 'Now we are all sitting round the table, the gentlemen, the French governess, the housekeeper, the children and I. But that's like what happens every day.' 'Go on looking at the picture; it will develop and become more specialized.' 'Yes, there is a guest. It's the chief accountant. He's an old man and he is as fond of the children as though they were his own grandchildren. But he comes to lunch so often that there's nothing special in that.' 'Be patient and just keep looking at the picture; something's sure to happen.' 'Nothing's happening. We're getting up from the table; the children say their good-byes, and they go upstairs with us as usual to the second floor.' 'And then?'

'It is a special occasion, after all. I recognize the scene now. As the children say good-bye, the accountant tries to kiss them. My employer flares up and actually shouts at him:

"Don't kiss the children!" I felt a stab at my heart; and as the gentlemen were already smoking, the cigar-smoke stuck in my memory.'

This, then, was a second and deeper-lying scene which, like the first, operated as a trauma and left a mnemic symbol behind it. But to what did this scene owe its effectiveness? 'Which of the two scenes was the earlier,' I asked, 'this one or the one with the burnt pudding?'—'The scene I have just told you about was the earlier by almost two months.'—'Then why did you feel this stab when the children's father stopped the old man? His reprimand wasn't aimed at you.'—'It wasn't right of him to shout at an old man who was a valued friend of his and, what's more, a guest. He could have said it quietly.'—'So it was only the violence of his expression that hurt you? Did you feel embarrassed on his account? Or perhaps you thought: "If he can be so violent about such a trivial thing with an old friend and guest, how much more so would he be with me if I were his wife."'—'No, that's not it.'—'But it had to do with his vehemence, hadn't it?'—'Yes, about the children being kissed. He has never liked that.'

And now, under the pressure of my hand, the memory of a third and still earlier scene emerged, which was the really operative trauma and which had given the scene with the chief accountant its traumatic effectiveness. It had happened a few months earlier still that a lady who was an acquaintance of her employer's came to visit them, and on her departure kissed the two children on the mouth. Their father, who was present, managed to restrain himself from saying anything to the lady, but after she had gone, his fury burst upon the head of the unlucky governess. He said he held her responsible if anyone kissed the children on the mouth, that it was her duty not to permit it and that she was guilty of a dereliction of duty if she allowed it; if it ever happened again he would entrust his children's upbringing to other hands. This had happened at a time when she still thought he loved her, and was expecting a repetition of their first friendly talk. The scene had crushed her hopes. She had said to herself: 'If he can fly out at me like this and make such threats over such a trivial matter, and one for which, moreover, I am not in the least responsible, I must have made a mistake. He can never have had any warm feelings for me, or they would have taught him to treat me with more

consideration. It was obviously the recollection of this distressing scene which had come to her when the chief accountant had tried to kiss the children and had been reprimanded by their father.

After this last analysis, when, two days later, Miss Lucy visited me once more, I could not help asking her what had happened to make her so happy. She was as though transfigured. She was smiling and carried her head high. I thought for a moment that after all I had been wrong about the situation, and that the children's governess had become the Director's fiancée. But she dispelled my notion. 'Nothing has happened. It's just that you don't know me. You have only seen me ill and depressed. I'm always cheerful as a rule. When I woke yesterday morning the weight was no longer on my mind, and since then I have felt well.' 'And what do you think of your prospects in the house?' 'I am quite clear on the subject. I know I have none, and I shan't make myself unhappy over it.' 'And will you get on all right with the servants now?' 'I think my own oversensitiveness was responsible for most of that.' 'And are you still in love with your employer?' 'Yes, I certainly am, but that makes no difference. After all, I can have thoughts and feelings to myself.'

[I then examined her nose and found that its sensitivity to pain and reflex excitability had been almost completely restored. She was also able to distinguish between smells, though with uncertainty and only if they were strong. I must leave it an open question, however, how far her nasal disorder may have played a part in the impoverishment of her sense of smell.]

This treatment lasted in all for nine weeks. Four months later I met the patient by chance in one of our summer resorts. She was in good spirits and assured me that her recovery had been maintained.

Discussion

I am not inclined to under-estimate the importance of the case that I have here described, even though the patient was suffering only from a slight and mild hysteria and though only a few symptoms were involved. On the contrary, it seems to me an instructive fact that even an illness such as this, so unproductive when regarded as a neurosis, called for so many

of Defence' (1896b).]

[illegible]

[1] [See footnote, p. 45 above.]

[2] [illegible] (1894a).]

Miss Lucy R.'s case the first of the auxiliary moments, at which conversion took place, was the scene at table when the chief accountant tried to kiss the children. Here the traumatic memory was playing a part: she did not behave as though she had got rid of everything connected with her devotion to her employer. In the history of other cases these different moments coincide: conversion occurs as an immediate effect of the trauma.)

The second auxiliary moment repeated the mechanism of the first one fairly exactly. A powerful impression temporarily re-united the patient's consciousness, and conversion once more took the path which had been opened out on the first occasion. It is interesting to notice that the second symptom to develop masked the first, so that the first was not clearly perceived until the second had been cleared out of the way. It also seems to me worth while remarking upon the reversed course which had to be followed by the analysis as well. I have had the same experience in a whole number of cases, the symptoms that had arisen later masked the earlier ones, and the key to the whole situation lay only in the last symptom to be reached by the analysis.

The therapeutic process in this case consisted in compelling the psychical group that had been split off to unite once more with the ego-consciousness. Strangely enough, success did not run *pari passu* with the amount of work done. It was only when the last piece of work had been completed that recovery suddenly took place.

CASE 4

Katharina —— (Freud)

In the summer vacation of the year 189– I made an excursion into the Hohe Tauern[1] so that for a while I might forget medicine and more particularly the neuroses. I had almost succeeded in this when one day I turned aside from the main road to climb a mountain which lay somewhat apart and which was renowned for its views and for its well-run refuge hut. I reached the top after a strenuous climb and, feeling refreshed and rested, was sitting deep in contemplation of the charm of the distant prospect. I was so lost in thought that at first I did not connect it with myself when these words reached my ears: 'Are you a doctor, sir?' But the question was addressed to me, and by the rather sulky-looking girl of perhaps eighteen who had served my meal and had been spoken to by the landlady as 'Katharina'. To judge by her dress and bearing, she could not be a servant, but must no doubt be a daughter or relative of the landlady's.

Coming to myself I replied: 'Yes, I'm a doctor: but how did you know that?'

'You wrote your name in the Visitors' Book, sir. And I thought if you had a few moments to spare.... The truth is, sir, my nerves are bad. I went to see a doctor in L— about them and he gave me something for them; but I'm not well yet.'

So there I was with the neuroses once again—for nothing else could very well be the matter with this strong, well-built girl with her unhappy look. I was interested to find that neuroses could flourish in this way at a height of over 6,000 feet; I questioned her further therefore. I report the conversation that followed between us just as it is impressed on my memory and I have not altered the patient's dialect.[2]

'Well, what is it you suffer from?'

'I get so out of breath. Not always. But sometimes it catches me so that I think I shall suffocate.'

[1] [One of the highest ranges in the Eastern Alps.]

[2] [No attempt has been made in the English translation to imitate the dialect.]

This did not, at first sight, sound like a nervous symptom. But soon it occurred to me that probably it was only a description that stood for an anxiety attack: she was choosing shortness of breath out of the complex of sensations arising from anxiety and laying undue stress on that single factor.

'Sit down here. What is it like when you get "out of breath"?'

'It comes over me all at once. First of all it's like something pressing on my eyes. My head gets so heavy, there's a dreadful buzzing, and I feel so giddy that I almost fall over. Then there's something crushing my chest so that I can't get my breath.'

'And you don't notice anything in your throat?'

'My throat's squeezed together as though I were going to choke.'

'Does anything else happen in your head?'

'Yes, there's a hammering, enough to burst it.'

'And don't you feel at all frightened while this is going on?'

'I always think I'm going to die. I'm brave as a rule and go about everywhere by myself—into the cellar and all over the mountain. But on a day when that happens I don't dare to go anywhere; I think all the time someone's standing behind me and going to catch hold of me all at once.'

So it was in fact an anxiety attack, and introduced by the signs of a hysterical 'aura'[1]—or, more correctly, it was a hysterical attack the content of which was anxiety. Might there not probably be some other content as well?

'When you have an attack do you think of something? and always the same thing? or do you see something in front of you?'

'Yes. I always see an awful face that looks at me in a dreadful way, so that I'm frightened.'

Perhaps this might offer a quick means of getting to the heart of the matter.

'Do you recognize the face? I mean, is it a face that you've really seen some time?'

'No.'

'Do you know what your attacks come from?'

'No.'

'When did you first have them?'

[1] [The premonitory sensations preceding an epileptic or hysterical attack.]

Two years ago, while I was [illegible] living on the other mountain [illegible] and we [illegible]

[illegible] I should have to try a lucky guess. I had found [illegible] enough [illegible]

'So', I said, '[illegible] I'll tell you how I think you got your attacks. At that time, two years ago, you must have seen or heard something that very much embarrassed you, and that you'd much rather not have seen.'

'Heavens, yes!' she replied, 'that was when I caught my uncle with the girl, with Franziska, my cousin.'

'What's this story about a girl? Won't you tell me all about it?'

'You can say anything to a doctor, I suppose. Well, at that [illegible] divorced, and [illegible] because it was through me that it came out that he was carrying on with Franziska.'

'And how did you discover it?'

'This way. One day two years ago some gentlemen had [illegible] My aunt wasn't at home, and Franziska, who always did the cooking, was nowhere to be found. And my uncle was not to be found either. We looked everywhere, and at last Alois, [illegible] my cousin, said: "Why, Franziska must be [illegible]"'

[illegible]

[illegible]

And we both laughed, but we weren't thinking anything bad. Then we went to my uncle's room but found it locked. That seemed strange to me. Then Alois said: "There's a window in the passage where you can look into the room." We went into the passage, but Alois wouldn't go to the window and said he was afraid. So I said: "You silly boy! I'll go. I'm not a bit afraid." And I had nothing bad in my mind. I looked in. The room was rather dark, but I saw my uncle and Franziska; he was lying on her.'

'Well?'

'I came away from the window at once, and leant up against the wall and couldn't get my breath—just what happens to me since. Everything went blank, my eyelids were forced together and there was a hammering and buzzing in my head.'

'Did you tell your aunt that very same day?'

'Oh no, I said nothing.'

'Then why were you so frightened when you found them together? Did you understand it? Did you know what was going on?'

'Oh no. I didn't understand anything at that time. I was only sixteen. I don't know what I was frightened about.'

'Fräulein Katharina, if you could remember now what was happening in you at that time, when you had your first attack, what you thought about it—it would help you.'

'Yes, if I could. But I was so frightened that I've forgotten everything.'

Translated into the terminology of our 'Preliminary Communication' [p. 12], this means: 'The affect itself created a hypnoid state, whose products were then cut off from associative connection with the ego-consciousness.'

'Tell me, Fräulein. Can it be that the head that you always see when you lose your breath is Franziska's head, as you saw it then?'

'Oh no, she didn't look so awful. Besides, it's a man's head.'

'Or perhaps your uncle's?'

'I didn't see his face as clearly as that. It was too dark in the room. And why should he have been making such a dreadful face just then?'

'You're quite right.'

The road suddenly seemed blocked. Perhaps something might turn up in the rest of her story.

'And what happened then?'

'Well, those two must have heard a noise, because they came out soon afterwards. I felt very bad the whole time. I always kept thinking about it. Then two days later it was a Sunday and there was a great deal to do and I worked all day long. And on the Monday morning I felt giddy again and was sick, and I stopped in bed and was sick without stopping for three days.'

We [Breuer and I] had often compared the symptomatology of hysteria with a pictographic script which has become intelligible after the discovery of a few bilingual inscriptions. In that alphabet being sick means disgust. So I said: 'If you were sick three days later, I believe that means that when you looked into the room you felt disgusted.'

'Yes, I'm sure I felt disgusted,' she said reflectively, 'but disgusted at what?'

'Perhaps you saw something naked? What sort of state were they in?'

'It was too dark to see anything; besides, both of them had their clothes on. Oh, if only I knew what it was I felt disgusted at!'

I had no idea either. But I told her to go on and tell me whatever occurred to her, in the confident expectation that she would think of precisely what I needed to explain the case.

Well, she went on to describe how at last she reported her discovery to her aunt, who found that she was changed and suspected her of concealing some secret. There followed some very disagreeable scenes between her uncle and aunt, in the course of which the children came to hear a number of things which opened their eyes in many ways and which it would have been better for them not to have heard. At last her aunt decided to move with her children and take over the present inn, leaving her uncle alone with Franziska, who had meanwhile become pregnant. After this, however, to my astonishment she dropped these threads and began to tell me two sets of older stories, which went back two or three years earlier than the traumatic moment. The first set related to occasions on which the same uncle had made sexual advances to her herself, when she was only fourteen years old. She described how she had once gone with him on an expedition down into the valley in the winter and had spent the night in the inn there. He sat in the bar drinking and playing cards, but she felt

sleepy and went up to bed early in the room they were to share on the upper floor. She was not quite asleep when he came up; then she fell asleep again and woke up suddenly 'feeling his body' in the bed. She jumped up and remonstrated with him: 'What are you up to, Uncle? Why don't you stay in your own bed?' He tried to pacify her: 'Go on, you silly girl, keep still. You don't know how nice it is.'—'I don't like your "nice" things; you don't even let one sleep in peace.' She remained standing by the door, ready to take refuge outside in the passage, till at last he gave up and went to sleep himself. Then she went back to her own bed and slept till morning. From the way in which she reported having defended herself it seems to follow that she did not clearly recognize the attack as a sexual one. When I asked her if she knew what he was trying to do to her, she replied: 'Not at the time.' It had become clear to her much later on, she said. She had resisted because it was unpleasant to be disturbed in one's sleep and 'because it wasn't nice.'

I have been obliged to relate this in detail, because of its great importance for understanding everything that followed. —She went on to tell me of yet other experiences of somewhat later date: how she had once again had to defend herself against him in an inn when he was completely drunk, and similar stories. In answer to a question as to whether on these occasions she had felt anything resembling her later loss of breath, she answered with decision that she had every time felt the pressure on her eyes and chest, but with nothing like the strength that had characterized the scene of discovery.

Immediately she had finished this set of memories she began to tell me a second set, which dealt with occasions on which she had noticed something between her uncle and Franziska. Once the whole family had spent the night in their clothes in a hay loft and she was woken up suddenly by a noise; she thought she noticed that her uncle, who had been lying between her and Franziska, was turning away, and that Franziska was just lying down. Another time they were stopping the night at an inn at the village of N——; she and her uncle were in one room and Franziska in an adjoining one. She woke up suddenly in the night and saw a tall white figure by the door, on the point of turning the handle: 'Goodness, is that you, Uncle? What are you doing at the door?'—'Keep quiet. I was only

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] and know all sorts of things . . .'

'Yes, now I am.'

'[illegible] you felt that night?'

[1] [Cf. below, p. 134.]

But she gave me no more [illegible] answer. [illegible] in an embarrassed way, as though she had been [illegible] who [illegible] has been reached [illegible] there is [illegible] I [illegible] what the [illegible] was [illegible] she has [illegible] Her [illegible] that I [illegible] But I [illegible] not [illegible] her and [illegible] a [illegible] to [illegible] the [illegible] whatever [illegible]

[illegible] the case [illegible] What [illegible] during her [illegible] [illegible] [illegible] I [illegible] [illegible] [illegible] she [illegible] Yes, I [illegible] I [illegible] I [illegible] the [illegible] was [illegible] rage [illegible] He [illegible] he would [illegible] he [illegible] with rage and [illegible] I always ran away [illegible] he [illegible] the [illegible] I always see [illegible] when he was in a rage."

[illegible] we were [illegible] what [illegible] been [illegible] her [illegible]

[illegible] of his making advances to you?"

"Yes. [illegible] there was a [illegible] in reserve. [illegible]

I [illegible] the last [illegible] and [illegible] in the [illegible] said,

[illegible]

I have not seen her since.

Discussion

[illegible]

[illegible]

[illegible] p. 2.3 below.]

[illegible] to another.

CASE 5

Fräulein Elisabeth von R. (Freud)

In the autumn of 1892 I was asked by a doctor I knew to examine a young lady who had been suffering for more than two years from pains in her legs and who had difficulties in walking. When making this request he added that he thought the case was one of hysteria, though there was no trace of the usual indications of that neurosis. He told me that he knew the family slightly and that during the last few years it had met with many misfortunes and not much happiness. First the patient's father had died, then her mother had had to undergo a serious eye-operation and soon afterwards a married sister had succumbed to a heart-affection of long standing after a confinement. In all these troubles and in all the sick-nursing involved, the largest share had fallen to our patient.

My first interview with this young woman of twenty-four years of age did not help me to make much further progress in understanding the case. She seemed intelligent and mentally normal and bore her troubles, which interfered with her social life and pleasures, with a cheerful air—the *belle indifférence* of a hysteric,[1] I could not help thinking. She walked with the upper part of her body bent forward, but without making use of any support. Her gait was not of any recognized pathological type, and moreover was by no means strikingly bad. All that was apparent was that she complained of great pain in walking and of being quickly overcome by fatigue both in walking and in standing, and that after a short time she had to rest, which lessened the pains but did not do away with them altogether. The pain was of an indefinite character; I gathered that it was something in the nature of a painful fatigue. A fairly large, ill-defined area of the anterior surface of the right thigh was indicated as the focus of the pains, from which they most often radiated and where they reached their greatest intensity. In this area the skin and muscles were also particularly sensitive to pressure and pinching (though the prick of a needle was, if

[1] Freud [illegible] this phrase again towards the end of his paper on repression [illegible]

[illegible] were [illegible] most sensitive to both these kinds of pain. [illegible] and [illegible] symptoms so that there was no ground for [illegible] the presence of any [illegible] developed [illegible] two years and [illegible] greatly in intensity.

[illegible]

[illegible] [These brackets are the author's.]

[illegible] was, and we are [illegible] her attention must be dwelling on something else, of which the pains were only an accessory [illegible] thoughts and feelings, therefore, which were connected with them.

[illegible] which is even more [illegible] view of the pains. [illegible] an area [illegible] face takes on an expression [illegible] and draws back [illegible] In the case of [illegible] her face assumed a peculiar expression [illegible] it was as though she was [illegible] her face [illegible], she threw back her head and shut her eyes and her body bent backwards. None of this was very exaggerated, but it was [illegible] with the view [illegible]

Her expression [illegible] with the pain which was [illegible] of her muscles and skin [illegible] with the subject-matter of the [illegible] the pain and which had [illegible] of the parts of the body [illegible] I had repeatedly [illegible] Her other gestures were [illegible] very slight hints of a hysterical attack.

To begin with there was no explanation of the unusual [illegible] The fact that the hyperalgesia [illegible] also gave food for thought. [illegible] disorder which is [illegible] and [illegible] to pressure in the [illegible]

[illegible] 'hysterical'.]

nervous affections. This possibility was not contradicted by the consistency of the patient's hyperalgesic muscles. There were numerous hard fibres in the muscular substance, and these seemed to be especially sensitive. Thus it was probable that an organic change in the muscles of the kind indicated was present and that the neurosis attached itself to this and made it seem of exaggerated importance.

Treatment proceeded on the assumption that the disorder was of this mixed kind. We recommended the continuation of systematic kneading and faradization of the sensitive muscles, regardless of the resulting pain, and I reserved to myself treatment of her legs with high tension electric currents, in order to be able to keep in touch with her. Her question whether she should force herself to walk was answered with a decided 'yes'.

In this way we brought about a slight improvement. In particular, she seemed to take quite a liking to the painful shocks produced by the high tension apparatus, and the stronger these were the more they seemed to push her own pains into the background. In the meantime my colleague was preparing the ground for psychical treatment, and when, after four weeks of my pretence treatment, I proposed the other method and gave her some account of its procedure and mode of operation, I met with quick understanding and little resistance.

The task on which I now embarked turned out, however, to be one of the hardest that I had ever undertaken, and the difficulty of giving a report upon it is comparable, moreover, with the difficulties that I had then to overcome. For a long time, too, I was unable to grasp the connection between the events in her illness and her actual symptom, which must nevertheless have been caused and determined by that set of experiences.

When one starts upon a cathartic treatment of this kind the first question one asks oneself is whether the patient herself is aware of the origin and the precipitating cause of her illness. If so, no special technique is required to enable her to reproduce the story of her illness. The interest shown in her by the physician, the understanding of her which he allows her to feel and the hopes of recovery he holds out to her—these will decide the patient to yield up her secret. From the beginning it seemed to me probable that Fräulein Elisabeth was conscious

[illegible]

keep her eyes tightly shut.

[illegible]

[illegible] taken in this.

[illegible] side of her character.

[illegible]

[illegible]

there came the certainty that they had [illegible] take
their leave of a living person.

[illegible]

[illegible] take [illegible] mother and her own pains.

If we put greater [illegible] traumas?

As far as the [illegible] a great [illegible]

[illegible] *whatever kind.*

Her [illegible]

my diagnosis. I could not help being reminded of old Herr von R.'s complaint about his favourite daughter—that she was 'cheeky' and 'ill-behaved'. But I was obliged to admit that she was in the right.

If I had stopped the patient's psychical treatment at this stage, the case of Fräulein Elisabeth von R. would clearly have thrown no light on the theory of hysteria. But I continued my analysis because I firmly expected that deeper levels of her consciousness would yield an understanding both of the causes and the specific determination of the hysterical symptoms. I therefore decided to put a direct question to the patient in an enlarged state of consciousness and to ask her what psychical impression it had been to which the first emergence of pains in her legs had been attached.

With this end in view I proposed to put the patient into a deep hypnosis. But unfortunately I could not help observing that my procedure failed to put her into any state other than the one in which she had made her recital. I was glad enough that on this occasion she refrained from triumphantly protesting: 'I'm not asleep, you know; I can't be hypnotized.' In this extremity the idea occurred to me of resorting to the device of applying pressure to the head, the origin of which I have described in my case history of Miss Lucy. I carried it out by instructing the patient to report to me faithfully whatever appeared before her inner eye or passed through her memory at the moment of the pressure. She remained silent for a long time and then, on my insistence, admitted that she had thought of an evening on which a young man had seen her home after a party, of the conversation that had taken place between them and of the feelings with which she had returned home to her father's sick-bed.

This first mention of the young man opened up a new vein of ideas the contents of which I now gradually extracted. It was a question here of a secret, for she had initiated no one, apart from a common friend, into her relations with the young man and the hopes attached to them. He was the son of a family with which they had long been on friendly terms and who lived near their former home. The young man, who was himself an orphan, was devotedly attached to her father and followed his advice in pursuing his career. He had extended

[illegible]

[illegible] p. 168 ff.]

[illegible] a fresh memory.

[illegible]

[illegible] *thenic* nature. [Cf. p. 175 *n*.]

I carried my [illegible] further and [illegible] that [illegible] every [illegible] area of pain had extended [illegible] fresh [illegible] what we were dealing with was not [illegible] from this subject.

I did, however, [illegible]

[illegible] [p. 142].

[illegible]

[illegible]

convinced of the trustworthiness of my technique. I no longer accepted her declaration that nothing had occurred to her, but assured her that something must have occurred to her. Perhaps, I said, she had not been sufficiently attentive, in which case I should be glad to repeat my pressure. Or perhaps she thought that her idea was not the right one. This, I told her, was not her affair; she was under an obligation to remain completely objective and say what had come into her head, whether it was appropriate or not. Finally I declared that I knew very well that something had occurred to her and that she was keeping it from me; but she would never be free of her pains so long as she concealed anything. By thus insisting, I brought it about that from that time forward my pressure on her head never failed in its effect. I could not but conclude that I had formed a correct opinion of the state of affairs, and I derived from this analysis a literally unqualified reliance on my technique. It often happened that it was not until I had pressed her head three times that she produced a piece of information; but she herself would remark afterwards: 'I could have said it to you the first time.'—'And why didn't you say it?'—'I thought it wasn't what was wanted', or 'I thought I could avoid it; but it came back each time.' In the course of this difficult work I began to attach a deeper significance to the resistance offered by the patient in the reproduction of her memories and to make a careful collection of the occasions on which it was particularly marked.[1]

I have now arrived at the third period of the treatment. The patient was better. She had been mentally relieved and was now capable of successful effort. But her pains had manifestly not been removed; they recurred from time to time, and with all their old severity. This incomplete therapeutic result corresponded to an incompleteness in the analysis. I still did not know exactly at what moment and by what mechanism the pains had originated. During the reproduction of the great variety of scenes in the second period and while I was observing the patient's resistance to telling me about them, I had formed a particular suspicion. I did not venture yet, however, to adopt it as the basis of my further action. But a chance occurrence

[1] [This is the first mention of the important clinical fact of resistance. It is discussed at greater length below (p. 268 ff.).]

made her way to the spot with a view which had been a favourite one of their walks. There she sat down and dreamt once again of enjoying such happiness as her sister's and of finding a man who would know how to capture her heart like this brother-in-law of hers. She was in pain when she stood up, but it passed off once more. It was not until the afternoon, when she had had a warm bath, that the pains broke out, and she was never again free from them. I tried to discover what thoughts were occupying her mind while she was having the bath; but I learnt only that the bath-house had reminded her of the members of her family who had gone away, because that was the building in which they had stayed.

It had long since become clear to me what all this was about; but the patient, deep in her bitter-sweet memories, seemed not to notice the end towards which she was steering and continued to reproduce her recollections. She went on to her visit to Gastein, the anxiety with which she looked forward to every letter, finally the bad news about her sister, the long wait till the evening, which was the first moment at which they could get away from Gastein, then the journey, passed in tormenting uncertainty, and the sleepless night—all of these accompanied by a violent increase in her pains. I asked her whether during the journey she had thought of the grievous possibility which was afterwards realized. She answered that she had carefully avoided the thought, but she believed that her mother had from the beginning expected the worst. Her memories now went on to their arrival in Vienna, the impression made on them by the relatives who met them, the short journey from Vienna to the summer resort in its neighbourhood where her sister lived, their reaching there in the evening, the hurried walk through the garden to the door of the small garden house, the silence within and the oppressive darkness; how her brother-in-law was not there to receive them, and how they stood before the bed and looked at her sister as she lay there dead. At that moment of dreadful certainty that her beloved sister was dead without bidding them farewell and without her having eased her last days with her care—at that very moment another thought had shot through Elisabeth's mind, and now forced itself irresistibly upon her once more, like a flash of lightning in the dark: 'Now he is free again and I can be his wife.'

made any impression on her.

everything she [illegible] and [illegible] her [illegible]
have accustomed her.

I was [illegible]

[illegible] likely to be achieved.

[illegible]
to spend the summer together.

[illegible]

attempt, she told me, to discuss her daughter's affairs of the heart with her, the girl had rebelled violently and had since then suffered from severe pains once more. She was indignant with me for having betrayed her secret. She was entirely inaccessible, and the treatment had been a complete failure. What was to be done now? she asked. Elisabeth would have nothing more to do with me. I did not reply to this. I [illegible] to reason that Elisabeth after leaving my care would make one more attempt to reject her mother's intervention and once more take refuge in isolation. But I had a kind of conviction that everything would come right and that the trouble I had taken had not been in vain. Two months later they were back in Vienna, and the colleague to whom I owed the introduction of the case gave me news that Elisabeth felt perfectly well and was behaving as though there was nothing wrong with her, though she still suffered occasionally from slight pains. Several times since then she has sent me similar messages and each time promised to come and see me. But it is a characteristic of the personal relationship which arises in treatments of this kind that she has never done so. As my colleague assures me, she is to be regarded as cured. Her brother-in-law's connection with the family has remained unaltered.

In the spring of 1894 I heard that she was going to a private ball for which I was able to get an invitation, and I did not allow the opportunity to escape me of seeing my former patient whirl past in a lively dance. Since then, by her own inclination, she has married someone unknown to me.

Discussion

I have not always been a psychotherapist. Like other neuropathologists, I was trained to employ local diagnoses and electro-prognosis, and it still strikes me myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. The fact is that local diagnosis and electrical reactions lead nowhere in the study of hysteria, whereas a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a

few psychological formulas, to obtain at least some kind of insight into the course of that affection. Case histories of this kind are intended to be judged like psychiatric ones; they have, however, one advantage over the latter, namely an intimate connection between the story of the patient's sufferings and the symptoms of his illness—a connection for which we still search in vain in the biographies of other psychoses.

In reporting the case of Fräulein Elisabeth von R. I have endeavoured to weave the explanations which I have been able to give of the case into my description of the course of her recovery. It may perhaps be worth while to bring together the important points once more. I have described the patient's character, the features which one meets with so frequently in hysterical people and which there is no excuse for regarding as a consequence of degeneracy: her giftedness, her ambition, her moral sensitiveness, her excessive demand for love which, to begin with, found satisfaction in her family, and the independence of her nature which went beyond the feminine ideal and found expression in a considerable amount of obstinacy, pugnacity and reserve. No appreciable hereditary taint, so my colleague told me, could be traced on either side of her family. It is true that her mother suffered for many years from a neurotic depression which had not been investigated; but her mother's brothers and sisters and her father and his family could be regarded as well-balanced people free from nervous trouble. No severe case of neuropsychosis had occurred among her near relatives.

Such was the patient's nature, which was now assailed by painful emotions, beginning with the lowering effect of nursing her beloved father through a long illness.

There are good reasons for the fact that sick-nursing should play such a significant part in the prehistory of cases of hysteria. A number of the factors at work in this are obvious: the disturbance of one's physical health arising from interrupted sleep, the neglect of one's own person, the effect of constant worry on one's vegetative functions. But, in my view, the most important determinant is to be looked for elsewhere. Anyone whose mind is taken up by the hundred and one tasks of sick-nursing which follow one another in endless succession over a period of weeks and months will, on the one hand, adopt a habit of suppressing every sign of his own emotion, and on the other, will soon

divert his attention away from his own impressions, since he has neither time nor strength to do justice to them. Thus he will accumulate a mass of impressions which are capable of affect, which are hardly sufficiently perceived and which, in any case, have not been weakened by abreaction. He is creating material for a 'retention hysteria'.[1] If the sick person recovers, all these impressions, of course, lose their significance. But if he dies, and the period of mourning sets in, during which the only things that seem to have value are those that relate to the person who has died, these impressions that have not yet been dealt with come into the picture as well; and after a short interval of exhaustion the hysteria, whose seeds were sown during the time of nursing, breaks out.

We also occasionally come across this same fact of the traumas accumulated during sick-nursing being dealt with subsequently, where we get no general impression of illness but where the mechanism of hysteria is nevertheless retained. Thus I am acquainted with a highly gifted lady who suffers from slight nervous states and whose whole character bears evidence of hysteria, though she has never had to seek medical help or been unable to carry on her duties. She has already nursed to the end three or four of those whom she loved. Each time she reached a state of complete exhaustion; but she did not fall ill after these tragic efforts. Shortly after her patient's death, however, there would begin in her a work of reproduction which once more brought up before her eyes the scenes of the illness and death. Every day she would go through each impression once more, would weep over it and console herself—at her leisure, one might say. This process of dealing with her impressions was dovetailed into her everyday tasks without the two activities interfering with each other. The whole thing would pass through her mind in chronological sequence. I cannot say whether the work of recollection corresponded day by day with the past. I suspect that this depended on the amount of leisure which her current household duties allowed.[2]

In addition to these outbursts of weeping with which she made up arrears and which followed close upon the fatal ter-

[1] [See p. 211 and footnote.]

[2] [In this account of the 'work of recollection' Freud seems to be anticipating the 'work of mourning' which he described much later in his paper 'Mourning and Melancholia' (1917e).]

who had no less strength of character than Fräulein von R., was astonished at the violent effect produced on her by these reminiscences.

I must emphasize once more that this woman was not ill and her postponed abreaction was not a hysterical process, however much it resembled one. We may ask why it should be that one instance of sick-nursing should be followed by a hysteria and another not. It cannot be a matter of individual predisposition, for this was present to an ample degree in the woman I have in mind.

But I must now return to Fräulein Elisabeth von R. While she was nursing her father, as we have seen, she for the first time developed a hysterical symptom—a pain in a particular area of her right thigh. It was possible by means of analysis to find an adequate elucidation of the mechanism of the symptom. It happened at a moment when the circle of ideas embracing her duties to her sick father came into conflict with the content of the erotic desire she was feeling at the time. Under the pressure of vivid self-reproaches she decided in favour of the former, and in doing so brought about her hysterical pain.

According to the view suggested by the conversion theory of hysteria what happened may be described as follows. She repressed the erotic idea from consciousness and transformed the amount of its affect into physical sensations of pain. It did not become clear whether she was presented with this first conflict on one occasion only or on several; the latter alternative is the more likely. An exactly similar conflict—though of higher ethical significance and even more clearly established by the analysis—developed once more some years later and led to an intensification of the same pains and to an extension beyond their original limits. Once again it was a circle of ideas of an erotic kind that came into conflict with all her moral ideas; for her inclinations centred upon her brother-in-law, and, both

time. In connection with these memories of her thoughts, her present life seemed to have the complete appearance of reality, like something in a dream. I had not succeeded in making her talk again. I often addressed her while she was in deep somnambulism and saw her burst into tears each time without ever answering me; and one day, round about the anniversary of her engagement, her whole state of depression passed off—an event which brought me the credit of a great therapeutic success by hypnotism.

We can answer this question if we take into account two facts which we can make use of as being established with certainty. (1) Simultaneously with the formation of this separate psychical group the patient developed her hysterical pains. (2) The patient offered strong resistance to the attempt to bring about an association between the separate psychical group and the rest of the content of her consciousness; and when, in spite of this, the connection was accomplished she felt great psychical pain. Our view of hysteria brings these two facts into relation with the splitting of her consciousness by asserting that the second of them indicates the *motive* for the splitting of consciousness, while the first indicates its *mechanism*. The motive was that of defence, the refusal on the part of the patient's whole ego to come to terms with this ideational group. The mechanism was that of conversion: i.e. in place of the mental pains which she avoided, physical pains made their appearance. In this way a transformation was effected which had the advantage that the patient escaped from an intolerable mental condition; though, it is true, this was at the cost of a psychical abnormality—the splitting of consciousness that came about—and of a physical illness—her pains, on which an astasia-abasia was built up.

I cannot, I must confess, give any hint of how a conversion of this kind is brought about. It is obviously not carried out in the same way as an intentional and voluntary action. It is a process which occurs under the pressure of the motive of defence in someone whose organization—or a temporary modification of it—has a proclivity in that direction.[1]

This theory calls for closer examination. We may ask: what is it that turns into physical pain here? A cautious reply would be: something that might have become, and should have become, mental pain. If we venture a little further and try to represent the ideational mechanism in a kind of algebraical picture, we may attribute a certain quota of affect to the ideational complex of these erotic feelings which remained unconscious, and say that this quantity (the quota of affect) is what was converted. It would follow directly from this description that the 'unconscious love' would have lost so much of its intensity through a conversion of this kind that it would have been reduced to

[1] [Cf. p. [illegible].—The term 'somatic compliance', used in the 'Dora' case history (*Standard Ed.*, 7, 4[illegible]), may perhaps refer to this proclivity.]

no more than a weak idea. This reduction of strength would then have been the only thing which made possible the existence of [illegible] as a separate psychical group. In the present case, however, [illegible] forced to give a clear picture of such a delicate matter. For in this case there was [illegible] others it can be shown with [illegible], and that if it the [illegible] idea has not been repressed [illegible] an idea of [illegible] can be. The patient's [illegible] connection with the [illegible] has been [illegible] that [illegible] had not [illegible]

I have asserted [illegible] that on certain occasions, though [illegible] the patient recognized her love for her brother-in-law [illegible]. As an example of this we may recall the moment when she was standing by her sister's bed and the thought flashed through her mind: 'Now he is free and you can be his wife.' [illegible] I must now consider the significance of these moments in their bearing on our view of the whole neurosis. It seems to me that the concept of a 'defence hysteria' in itself implies that at least one moment of this kind must have occurred. Consciousness, plainly, does not know in advance when an incompatible idea is going to crop up. The incompatible idea, which, together with its concomitants, is later excluded and forms a separate psychical group, must originally have been in communication with the main stream of thought.[1] Otherwise the conflict which led to their exclusion could not have taken place. It is these moments, then, that are to be described as 'traumatic': it is at these moments that conversion takes place, of which the results are the splitting of consciousness and the hysterical symptom. In the case of Fräulein Elisabeth von R. everything points to there having been several such moments—the scenes of the walk, the morning reverie, the bath, and at her sister's bedside. It is even possible that new moments of the same kind happened during the treatment. What makes it possible for there to be several of these traumatic moments is that an experience similar to the one which originally introduced the incompatible idea adds

[1] It is otherwise in hypnoid hysteria, where the content of the separate psychical group would never have been in the ego-consciousness. [Cf. p. 285.]

[illegible] the separated [illegible] group and [illegible] [illegible] the success of the [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] was [illegible] in her [illegible] [illegible] [illegible] have been [illegible] to the occurrence [illegible] [illegible] [illegible] preferred a [illegible] in which the [illegible] history lay wholly in the past.

[illegible] a point which I have described [illegible] [illegible] understanding of [illegible] [illegible] I assumed [illegible] [illegible] was [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] and no [illegible] It is true that [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] her father's illness and [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] in the explanatory value of an analysis such as this?

[illegible] assuming that the

pains—the products of conversion—did not occur while the patient was experiencing the impressions of the first period, but only after the event—that is, in the second period, while she was reproducing those impressions in her thoughts. That is to say, the conversion did not take place in connection with her impressions when they were fresh, but in connection with her memories of them. I even believe that such a course of events is nothing unusual in hysteria and indeed plays a regular part in the genesis of hysterical symptoms. But since an assertion like this is not self-evident, I will try to make it more plausible by bringing forward some other instances.

It once happened to me that a new hysterical symptom developed in a patient during the actual course of an analysis treatment of this kind, so that I was able to set about getting rid of it on the day after its appearance. I will interpolate the main features of the case at this point. It was a fairly simple one, yet not without interest.

Fräulein Rosalia H., aged twenty-three, had for some years been undergoing training as a singer. She had a good voice, but she complained that in certain parts of its compass it was not under her control. She had a feeling of choking and constriction in her throat so that her voice sounded tight. For this reason her teacher had not yet been able to consent to her appearing in public as a singer. Although this imperfection only affected her middle register, it could not be attributed to a defect in the organ itself. At times the disturbance was completely absent and her teacher expressed great satisfaction; at other times, if she was in the least agitated, and sometimes without any apparent cause, the constricted feeling would recur and the production of her voice was impeded. It was not difficult to recognize a hysterical conversion in this very troublesome feeling. I did not take steps to discover whether there was in fact a contracture of some of the muscles of the vocal cords.[1] In the course of the hypnotic analysis which I

[1] I had another case of a singer under my observation in whom a contracture of the masseters made it impossible for her to practise her art. This young woman had been obliged to go on the stage by unfortunate events in her family. She was singing at a rehearsal in Rome at a time when she was in a state of great emotional excitement, and suddenly had a feeling that she could not close her open mouth, and fell to the floor in a faint. The doctor who was called in brought her

[illegible]

[illegible] The [illegible] difficulty.

[illegible]

[illegible]

[illegible] 211 and footnote.]

[illegible] German editions.]

[illegible]

[illegible] order stated in the footnote on p. 75.]

this last moment [illegible] I was a [illegible] discussion [illegible] the [illegible] in which she was concerned and which should have made her leave the house, while in fact she was obliged to stay at Vienna on account of the treatment and had to [illegible] else where she could be put up. The movement of her fingers which I saw her make while she was reproducing this scene was one of twisting something away, in the way in which one literally and figuratively brushes something aside—tosses away a piece of paper or rejects a suggestion.

She was quite definite in her assurance that she had not noticed these pains on previous days—that they had not been occasioned by the scenes she had first described. We must therefore suppose that the event of the previous day had in the first instance aroused the memory of earlier events with a similar content and that the mnemic symbol had been formed which appeared to the whole group of memories. The energy for the conversion had been supplied, on the one hand, by freshly experienced affect and, on the other hand, by recollected affect.

When we consider the question more closely we must recognize that a process of this kind is the rule rather than the exception in the genesis of hysterical symptoms. Almost invariably when I have investigated the determinants of such conditions what I have come upon has not been a single traumatic cause but a group of similar ones. (Cf. the case of Frau Emmy von N.—Case History 2.) In some of these instances it could be established that the symptom in question had already appeared for a short time after the first trauma and had then passed off, till it was brought on again and stabilized by a succeeding trauma. There is, however, in principle no difference between the symptom appearing in this temporary way after its first provoking cause and its being latent from the first. Indeed, in the great majority of instances we find that a first trauma has left no symptom behind, while a later trauma of the same kind produces a symptom, and yet that the latter could not have come into existence without the co-operation of the earlier provoking cause; nor can it be cleared up without taking all the provoking causes into account.

Stated in terms of the conversion theory, this incontrovertible fact of the summation of traumas and of the preliminary

latency of two years, it is just that conversion takes place equally from fresh symptoms and from recollected ones, and this theory explains the apparent contradiction which we observed between the events of Fräulein Elisabeth von R.'s illness and her analysis. There is no doubt that the continued existence in consciousness of ideas whose affect has not been dealt with can be tolerated by healthy people to a great amount. The view which I have just been putting forward does no more than bring the behaviour of hysterics, as far as possible, nearer to that of healthy people. What we are concerned with is clearly a quantitative factor—the question of how much affective tension of this kind an organism can tolerate. Even a hysteric can retain a certain amount of affect that has not been dealt with; if, owing to the occurrence of similar precipitating causes, that amount is increased by summation to a point beyond the subject's tolerance, the impetus to conversion is given. Thus when we say that the construction of hysterical symptoms can proceed on the strength of retained affects as well as fresh ones, we shall not be making any unfamiliar assertion, but stating something that is almost accepted as a postulate.

I have now discussed the motives and mechanism of this case of hysteria; it remains for me to consider how precisely the hysterical symptom was determined. Why was it that the patient's mental pain came to be represented by pains in the legs rather than elsewhere? The circumstances indicate that this somatic pain was not created by the neurosis but merely used, increased and maintained by it. I may add at once that I have found a similar state of things in almost all the instances of hysterical pains into which I have been able to obtain an insight. There had always been a genuine, organically-founded pain present at the start. It is the commonest and most widespread human pains that seem to be most often chosen to play a part in hysteria: in particular, the periosteal and neuralgic pains accompanying dental disease, the headaches that arise from so many different sources and, not less often, the rheumatic muscular pains that are so often unrecognized. In the same way I attribute an organic basis to Fräulein Elisabeth von R.'s first attack of pain which occurred as far back as while she was nursing her father. I obtained no result when I tried to discover a psychical cause for it; and I am inclined, I must confess, to attribute a power

of [illegible] to my method of [illegible] was [illegible] her painful psychical [illegible] and [illegible] as I can see [illegible] the most [illegible] of these [illegible] was that the pain was present in her consciousness at about the same time [illegible] In the second place it was [illegible] along a [illegible] with [illegible] at the time. The pain [illegible] have been [illegible] of the period of nursing [illegible] of exercise and [illegible] But the girl had no clear knowledge of [illegible] have had the pain during that time [illegible] when she sprang out of bed [illegible] But what [illegible] have had a [illegible] was [illegible] the fact that [illegible] a long [illegible] her [illegible] with her [illegible] were [illegible] was [illegible] the [illegible] of her pains and the [illegible] from which [illegible] It [illegible] the pain [illegible]

If anyone [illegible] between [illegible] pain and psychical [illegible] being [illegible] that [illegible] is as [illegible] that [illegible] the [illegible] who [illegible] there are [illegible] was not, in fact, [illegible] I can affirm that the [illegible] of Fräulein Elisabeth von R. was [illegible] determination [illegible] I have [illegible] the case of Frau Cäcilie M.

It may, however, have been of a [illegible] p. 148 n.]

[The allusion is to an epigram of Lessing's which Freud quotes in [illegible] *The Interpretation of Dreams* [illegible] *Ed.*, 4, 176).]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

¹ [See footnote, p. 126.]

III

THEORETICAL

(Breuer)



JOSEPH BREUER IN 1897

III

THEORETICAL

(Breuer)

In the 'Preliminary Communication' which introduces this work we stated the conclusions to which we were led by our observations, and I think that I can stand by them in the main. But the 'Preliminary Communication' is so short and concise that for the most part it was only possible in it to hint at our views. Now, therefore, that the case histories have brought forward evidence in support of our conclusions it may be permissible to state them at greater length. Even here, there is, of course, no question of dealing with the whole field of hysteria. But we may give a somewhat closer and clearer account, with some added reservations, no doubt, of those points for which insufficient evidence was adduced or which were not given enough prominence in the 'Preliminary Communication'.

In what follows little mention will be made of the brain and none whatever of molecules. Psychical processes will be dealt with in the language of psychology; and, indeed, it cannot possibly be otherwise. If instead of 'idea' we chose to speak of 'excitation of the cortex', the latter term would only have any meaning for us in so far as we recognized an old friend under that cloak and tacitly reinstated the 'idea'. For while ideas are constant objects of our experience and are familiar to us in all their shades of meaning, 'cortical excitations' are on the contrary rather in the nature of a postulate, objects which we hope to be able to identify in the future. The substitution of one term for another would seem to be no more than a pointless disguise. Accordingly, I may perhaps be forgiven if I make almost exclusive use of psychological terms.

There is another point for which I must ask in advance for the reader's indulgence. When a science is making rapid advances, thoughts which were first expressed by single individuals quickly become common property. Thus no one who attempts to put forward to-day his views on hysteria and its psychical basis

psychical facts can avoid repeating a great quantity of other people's thoughts which are in the act of passing from personal into general possession. It is scarcely possible always to be certain who first gave them utterance, and there is always a danger of regarding as a product of one's own what has already been said by someone else. I hope, therefore, that I may be excused if few quotations are found in this discussion and if no strict distinction is made between what is my own and what originates elsewhere. Originality is claimed for very little of what will be found in the following pages.

(1) Are All Hysterical Phenomena Ideogenic?

In our 'Preliminary Communication' we discussed the psychical mechanism of 'hysterical phenomena', not of 'hysteria', because we did not wish to claim that this psychical mechanism or the psychical theory of hysterical symptoms in general has unlimited validity. We are not of the opinion that all the phenomena of hysteria come about in the manner described by us in that paper, nor do we believe that they are all ideogenic, that is, determined by ideas. In this we differ from Moebius, who in 1888 proposed to define as hysterical all pathological phenomena that are caused by ideas. This statement was later elucidated to the effect that only a part of the pathological phenomena correspond in their content to the ideas that cause them—those phenomena, namely, that are produced by allo- or auto-suggestion, as for instance when the idea of not being able to move one's arm causes a paralysis of it; whereas another part of the hysterical phenomena, though caused by ideas, do not correspond to them in their content—as, for instance, when in one of our patients a paralysis of the arm was caused by the sight of snake-like objects [p. [illegible]].

In giving this definition, Moebius is not merely proposing a modification in nomenclature and suggesting that in future we should only describe as hysterical those pathological phenomena which are ideogenic (determined by ideas); what he thinks is that all hysterical symptoms are ideogenic. 'Since ideas are very frequently the cause of hysterical phenomena, I believe that they always are.' He terms this an inference by analogy. I prefer to call it a generalization, the justification for which must first be tested.

Before any discussion of the subject, we must obviously define what we understand by hysteria. I regard hysteria as a clinical picture which has been empirically discovered and is based on observation, in just the same way as tuberculous pulmonary phthisis. Clinical pictures of this kind that have been arrived at empirically are made more precise, deeper and clearer by the progress of our knowledge, but they ought not to be and cannot be disrupted by it. Aetiological research has shown that the various constituent processes of pulmonary phthisis have various causes: the tubercle is due to bacillus Kochii and the disintegration of tissue, the formation of cavities and the septic fever are due to other microbes. In spite of this, tuberculous phthisis remains a clinical unity and it would be wrong to break it up by attributing exclusively the specifically tuberculous modifications of tissue caused by Koch's bacillus and by separating the other manifestations from it. In the same way hysteria must remain a clinical unity even if it turns out that its phenomena are determined by various causes, and that some of them are brought about by a psychical mechanism and others without it.

It is my conviction that this is in fact so; only a part of the phenomena of hysteria are ideogenic, and the definition put forward by Moebius tears in half the clinical unity of hysteria, and indeed the unity of one and the same symptom in the same patient.

We should be drawing an inference completely analogous to Moebius's inference by analogy if we were to say that because ideas and perceptions very often give rise to erections we may assume that they alone ever do so, and that peripheral stimuli set this vasomotor process in action only by a roundabout path through the psyche. We know that this inference would be false, yet it is based on at least as many facts as Moebius's assertion about hysteria. In conformity with our experience of a large number of physiological processes, such as the secretion of saliva or tears, changes in the action of the heart, etc., it is possible and plausible to assume that one and the same process may be set in motion equally by ideas and by peripheral and other non-psychical stimuli. The contrary would need to be proved and we are very far short of that. Indeed, it seems certain that many phenomena which are described as hysterical are not caused by ideas alone.

Let us consider an everyday instance. A woman may, whenever an affect arises, produce on her neck, breast and face an erythema appearing first in blotches and then becoming confluent. This is determined by ideas and therefore according to Moebius it is a hysterical phenomenon. But the same erythema appears, though over a less extensive area, when the skin is irritated or touched, etc. This would not be hysterical. Thus a phenomenon which is undoubtedly a complete unity would on one occasion be hysterical and on another occasion not. It may of course be questioned whether this phenomenon, the erethism of the vasomotors, should be regarded as a specifically hysterical one or whether it should not be more properly regarded simply as "nervous." But on Moebius's view the breaking up of the unity would necessarily result in any case and the affectively determined erythema would alone be called hysterical.

It is always in exactly the same way with the hysterical pains which are of so much practical importance. No doubt these are often determined directly by ideas; they are "hallucinations of pain." If we examine these rather more closely it appears that the fact of an idea being very vivid is not enough to produce them, but that there must be a special abnormal condition of the apparatuses concerned with the conduction and sensation of pain, just as in the case of affective erythema an abnormal excitability of the vasomotors must be present. The phrase "hallucinations of pain" undoubtedly gives the most pregnant description of the nature of these neuralgias, but it also forces us to carry over to them the views that we have formed on hallucinations in general. A detailed discussion of these views would not be in place here. I adhere to the opinion that ideas, mnemic images pure and simple, without any excitation of the perceptual apparatus, never, even at their greatest vividness and intensity, attain the character of objective existence which is the mark of hallucinations.[1]

[1] This perceptual apparatus, including the sensory areas of the cortex, must be different from the organ which stores up and reproduces sense impressions in the form of mnemic images. For the basic essential of the function of the perceptual apparatus is that its status quo ante must be capable of being restored with the greatest possible rapidity; otherwise no proper further perception could take place. The essential of memory, on the other hand, is that no such restoration should occur, but that every perception should create changes that are permanent. It is impossible for one and the same organ to fulfil these two contra-

has been caused by ideas.

something about this causal relation on the basis of our observations. In our exposition of the subject, however, we introduced and employed without apology the concept of excitations which flow away or have to be abreacted.[1] This concept is of fundamental importance for our theme and for the theory of the neuroses in general, and it seems to demand and to deserve a more detailed examination. Before I proceed to this, I must ask to be forgiven for taking the reader back to the basic problems of the nervous system. A feeling of oppression is bound to accompany any such descent to the 'Mothers' [i.e., exploration of the depths].[2]

But any attempt at getting at the roots of a phenomenon inevitably leads in this way to basic problems which cannot be evaded. I hope therefore that the abstruseness of the following discussion may be viewed with indulgence.

2. Intracerebral Tonic Excitations—Affects

(A)

We know two extreme conditions of the central nervous system: a clear waking state and dreamless sleep. A transition between these is afforded by conditions of every degree of decreasing clarity. What interests us here is not the question of the purpose of sleep and its physical basis (its chemical or vasomotor determinants) but the question of the essential distinction between the two conditions.

We can give no direct information about the deepest, dreamless sleep, for the very reason that all observations and experiences are excluded by the state of total unconsciousness. But as regards the neighbouring condition of sleep accompanied by dreams, the following assertions can be made. In the first place, when in that condition we intend to make voluntary movements—of walking, speaking, etc.—this does not result in the corresponding contractions of the muscles being voluntarily innervated, as they are in waking life. In the second place, sensory stimuli

[1] [This is not an actual quotation from the 'Preliminary Communication', where this underlying hypothesis is nowhere explicitly mentioned. Cf. the remarks on this in the Editor's Introduction, p. xix ff.]

[2] [An allusion to Faust's mysterious researches (in Goethe's *Faust*, Part II, Act I).]

are perhaps perceived, for they often make their way into dreams; but they are not apperceived, i.e. do not become consciously perceived. Again, ideas that emerge do not, as in waking life, activate all the ideas which are connected with them and which are present in potential consciousness; a great number of the latter remain unexcited. (For instance, we find ourselves talking to a dead person without remembering that he is dead.) Incompatible ideas can be present simultaneously without mutually inhibiting each other, as they do in waking life. Thus, association is defective and incomplete. We may safely assume that in the deepest sleep this severance of connections between the psychical elements is carried still further and becomes total.

On the other hand, when we are fully awake every act of will initiates the corresponding movement; sense impressions become conscious perceptions; and ideas are associated with the whole store present in potential consciousness. In that condition the brain functions as a unit with complete internal connections.

We shall perhaps only be describing these facts in other words if we say that in sleep the paths of connection and conduction in the brain are not traversable by excitations of the psychical elements (? cortical cells), whereas in waking life they are completely so traversable.

The existence of these two different conditions of the paths of conduction can, it seems, only be made intelligible if we suppose that in waking life those paths are in a state of tonic excitation (what Exner [1894, 93] calls 'intercellular tetanus'), that this tonic intracerebral excitation is what determines their conductive capacity, and that the diminution and disappearance of that excitation is what sets up the state of sleep.

We ought not to think of a cerebral path of conduction as resembling a telephone wire which is only excited electrically at the moment at which it has to function (that is, in the present context, when it has to transmit a signal). We ought to liken it to a telephone line through which there is a constant flow of galvanic current and which can no longer be excited if that current ceases. Or better, let us imagine a widely-ramified electrical system for lighting and the transmission of motor power; what is expected of this system is that simple establishment of a contact shall be able to set any lamp or machine in

[illegible]

[illegible] consumption of energy.

[illegible]

[illegible] ously-published 'Project' (1950a).]

at rest. We may rightly suppose that in such a brain all the paths of conduction are at the maximum of their conductive capability—that they are in a state of tonic excitation. It is a noteworthy fact that in ordinary language we speak of such a state as one of tension. Experience teaches us what a strain this state is and how fatiguing, though no actual motor or physical work is performed in it.

This is an exceptional state, which, precisely on account of the great consumption of energy involved, cannot be tolerated for long. But even the normal state of being wide awake calls for an amount of intracerebral excitation varying between limits that are not very widely separated. Every one of the descending degrees of wakefulness down to drowsiness and true sleep is accompanied by correspondingly lower degrees of excitation.

When the brain is performing actual work, a greater consumption of energy is no doubt required than when it is merely *prepared* to perform work. (In just the same way the electrical system described above by way of comparison must cause a greater amount of electrical energy to flow into the conducting lines when a large number of lamps or motors are switched into the circuit.) Where functioning is normal no more energy is liberated than is immediately consumed in activity. The brain, however, behaves like one of those restricted systems of limited capacity which are unable to produce both a large amount of light and of mechanical work at the same time. If it is transmitting power, only a little energy is available for lighting, and vice versa. Thus we find that if we are making great muscular efforts we are unable to engage in continuous thought, or that if we concentrate our attention in one sensory field the efficiency of the other cerebral organs is reduced—that is to say, we find that the brain works with a varying but limited amount of energy.

The non-uniform distribution of energy is probably determined by what Exner [1894, 165] calls 'facilitation by attention'—by an increase in the conductive capacity of the paths in use and a decrease in that of the others; and thus in a working brain the 'intracerebral tonic excitation', too, is non-uniformly distributed.[1]

[1] The conception of the energy of the central nervous system as being a quantity distributed over the brain in a changing and fluctuating manner is an old one. 'La sensibilité', wrote Cabanis [illegible]

We wake up a person who is sleeping—that is, we suddenly raise the quantity of his tonic intracerebral excitation—by bringing a lively sensory stimulus to bear on him. Whether alterations in the blood-circulation in the brain are essential links here in the causal chain, and whether the blood-vessels are directly dilated by the stimulus, or whether the dilatation is a consequence of the excitation of the cerebral elements—all this is undecided. What is certain is that the state of excitation, entering through a gateway of the senses, spreads over the brain from that point, becomes diffused and brings all the paths of conduction into a state of higher facilitation.

It is still not in the least clear, of course, how *spontaneous* awakening occurs—whether it is always one and the same portion of the brain that is the first to enter a state of waking excitation and the excitation then spreads from it, or whether sometimes one and sometimes another group of elements acts as the awakener. Nevertheless, spontaneous awakening, which, as we know, can take place in complete quiet and darkness without any external stimulus, proves that the development of energy is based on the vital process of the elements themselves. A muscle remains unstimulated, quiescent, however long it has been in a state of rest and even though it has accumulated a maximum of tensile force. This is not so with the cerebral elements. We are no doubt right in supposing that during sleep the latter regain their previous condition and gather tensile force. When this has happened to a certain degree, when, as we may say, a certain level has been reached, the surplus flows away into the paths of conduction, facilitates them and sets up the intracerebral excitation of the waking state.

We can find an instructive example of the same thing in waking life. When the waking brain has been at rest for a considerable time without transforming tensile force into vital energy by functioning, there arises a need and an urge for activity. Long motor quiescence creates a need for movement [illegible]

[illegible] ... whose ... greater ... becomes proportionately less ...]

(B)

causes of increases of excitation

'excitement', 'agitation')

[illegible] abstinence from narcotics.

[illegible] completely extinguished.

[illegible] misprinted 'Organismus'.]

Perception too (the psychical interpretation of sense-impressions) is impaired. An animal which is ordinarily timid and cautious becomes blind and deaf to danger. On the other hand, at least in males, there is an intensification of the aggressive instinct. Peaceable animals become dangerous until their excitation has been discharged in the motor activities of the sexual act.

(C)

A disturbance of this kind of the dynamic equilibrium of the nervous system—a non-uniform distribution of increased excitation—is what makes up the psychical side of affects.

No attempt will be made here to formulate either a psychology or a physiology of the affects. I shall only discuss a single point which is of importance for pathology, and moreover only for ideogenic affects—those which are called up by perceptions and ideas. [Lange [illegible] has rightly pointed out that affects can be caused by toxic substances [illegible]

[illegible]]

It must be taken as self-evident that all the disturbances of mental equilibrium which we call acute affects go along with an increase of excitation. (In the case of chronic affects, such as sorrow and care, that is to say protracted anxiety, the complication is present of a state of severe fatigue which, though it maintains the uneven distribution of excitation, nevertheless reduces its height.) But this increased excitation cannot be employed in psychical activity. All powerful affects restrict association—the train of ideas. People become 'senseless' with anger or fright. Only the group of ideas which provoked the affect persists in consciousness, and it does so with extreme intensity. Thus the excitement cannot be levelled out by associative activity.

Affects that are 'active' or 'sthenic' do, however, level out the increased excitation by motor discharge. Shouting and jumping for joy, the increased muscular tone of anger, angry words and retaliatory deeds—all these allow the excitation to flow away in motor acts. Mental pain discharges it in difficult breathing and in an act of secretion: in sobs and tears. It is a matter of everyday experience that such reactions reduce excitement and allay it. As we have already remarked [p. [illegible]],

ordinary language expresses this in such phrases as 'to cry oneself out', 'to blow off steam', etc. What is being got rid of is nothing else than the increased cerebral excitation.

Only some of these reactions—such as aggressive deeds and words—serve any purpose in the sense of making any change in the actual state of affairs. The rest serve no purpose whatever, or rather their only purpose is to level out the increase of excitation and to establish psychical equilibrium. So far as they achieve this they serve the 'tendency to keep intracerebral excitation constant' [p. 197].

The 'asthenic' affects of fear and anxiety do not bring about this reactive discharge. Fright paralyses outright the power of movement as well as of association, and so does anxiety if the one useful reaction of running away is excluded either by the cause of the affect of anxiety or by circumstances. The excitation of fright disappears only by a gradual levelling out.

Anger has adequate reactions corresponding to its cause. If these are not feasible, or if they are inhibited, they are replaced by substitutes. Even abusive words are substitutes of this kind. But other, even quite purposeless, acts may appear as substitutes. When Bismarck had to suppress his angry feelings in the King's presence, he relieved himself afterwards by smashing a valuable vase on the floor. This deliberate replacement of one motor act by another corresponds exactly to the replacement of natural pain-reflexes by other muscular contractions. When a tooth is extracted the preformed reflex is to push away the dentist and utter a cry. If, instead of that, we contract the muscles of our arms and press against the sides of the chair, we are shifting the quantum of excitation that has been generated by the pain from one group of muscles to another. [Cf. p. 91.] In the case of violent spontaneous toothache, where there is no preformed reflex apart from groaning, the excitation flows off in aimless walking up and down. In the same way we transpose the excitation of anger from the adequate reaction to another one, and we feel relieved provided it is used up by any strong motor innervation.

If, however, the affect is denied any discharge of excitation of any kind whatever, then the situation is the same with anger as with fright and anxiety: the intracerebral excitation is powerfully increased, but is used up neither in associative nor in motor activity. In normal people the disturbance is

[illegible] But in some abnormal reactions appear [illegible] expression of the emotions [illegible] as [illegible] [1890] says, is formed.

[illegible] Hysterical Conversion

[illegible]

[illegible] the smallest provocation.

[illegible]

against the passage of cerebral excitation to the vegetative organs. These resistances correspond to the insulation of electrical conducting lines. At points at which they are abnormally weak they are broken through when the tension of cerebral excitation is high, and this—the affective excitation—passes over to the peripheral organs. There ensues an 'abnormal expression of emotion'.

Of the two factors which we have mentioned as being responsible for this result, one has already been discussed by us in detail. The first factor is a high degree of intracerebral excitation which has failed to be levelled down either by ideational activities or by motor discharge, or which is too great to be dealt with in this way.

The second factor is an abnormal weakness of the resistances in particular paths of conduction. This may be determined by the initial constitution of the subject (innate disposition); or it may be determined by states of excitation of long duration which, as one might say, loosen the whole structure of his nervous system and lower all its resistances (pubertal disposition); or it may be determined by weakening influences such as illness and under-nourishment (disposition due to states of exhaustion). The resistance of particular paths of conduction may be lowered by a previous illness of the organ concerned which has facilitated the paths to and from the brain. A diseased heart is more susceptible to the influence of an affect than a healthy one. 'I have a sounding-board in my abdomen,' I was told by a woman who suffered from parametritis. 'Anything happens, it starts up my old pain.' (Disposition through local illness.)

The motor actions in which the excitation of affects is normally discharged are ordered and co-ordinated even though they are often useless. But an excessively strong excitation may by-pass or break through the co-ordinative centres and flow off in elementary movements. In infants, apart from the respiratory act of screaming, affects only produce and find expression in uncoordinated contractions of the muscles of this primitive kind—in arching the body and kicking about. As development proceeds, the musculature passes more and more under the control of the power of co-ordination and the will. But the opisthotonus, which represents the maximum of motor effort of the total somatic musculature, and the clonic move-

ments (kicking and hitting about, [illegible]) as the form of reaction for the maximal excitation of the brain, for the purely pathological excitation in epileptic attacks as well as for the discharge of unmanageable affects in the shape of more or less epileptoid convulsions (viz. the purely motor part of hysterical attacks).

It is true that abnormal affective reactions of this kind are characteristic of hysteria. But they also occur apart from that illness. What they indicate is a more or less high degree of nervous disorder, not hysteria. Such phenomena cannot be described as hysterical if they appear as consequences of an affect which, though of great intensity, has an objective basis, but only if they appear with apparent spontaneity as manifestations of an illness. These latter, as many observations, including our own, have shown, are based on recollections which revive the original affect—or rather, *which would revive it if those reactions did not, in fact, occur instead.*

It may be taken for granted that a stream of ideas and recollections runs through the consciousness of any reasonably intelligent person while his mind is at rest. These ideas are so little vivid that they leave no trace behind in the memory and it is impossible afterwards to say how the association occurred. If, however, an idea comes up that originally had a strong affect attached to it, that affect is revived with more or less intensity. The idea which is thus 'coloured' by affect emerges in consciousness clearly and vividly. The strength of the affect which can be released by a memory is very variable, according to the amount to which it has been exposed to 'wearing away' by different influences, and especially according to the degree to which the original affect has been 'abreacted'. We pointed out in our 'Preliminary Communication' [illegible] to what a varying extent the affect of anger at an insult, for instance, is called up by a recollection according to whether the insult has been repaid or endured in silence. If the psychical reflex was fully achieved on the original occasion, the recollection of it releases a far smaller quantity of excitation.[1] If the [illegible]

[1] The instinct of revenge, which is so powerful in the natural man and is disguised rather than repressed by civilization, is nothing whatever but the excitation of a reflex that has not been released. To defend oneself against injury in a fight and, in so doing, to [illegible]

[illegible] perpetually [illegible] the [illegible] abuse or words which were [illegible], and which would have been the psychical reaction to the [illegible].

If the [illegible] affect was discharged [illegible] in an abnormal reflex, this latter is equally released by recollection. The excitation arising from the affective idea is 'converted' [illegible] into a [illegible] phenomenon.

Should that abnormal reflex become completely facilitated by frequent repetition, it may, it seems, draw away the operative force of the releasing ideas so entirely that the affect itself emerges to a minimal extent only or not at all. In such a case the 'hysterical conversion' is complete. The idea, moreover, which now no longer produces any psychical consequences may be overlooked by the patient, or may be promptly forgotten if it emerges, like any other idea which is unaccompanied by affect.

It may be easier to accept the possibility of a cerebral excitation which should have given rise to an idea being released in this way by an excitation of some peripheral part, if we call to mind the inverse course of events which follows when a preformed reflex fails to occur. I will select an example from ordinary experience—the sneezing reflex. If a stimulus of the mucous membrane of the nose fails for any reason to release this preformed

[illegible]

[illegible]
[illegible]

[illegible] Messina, III, 5.]

[illegible] near the beginning of [illegible] [illegible] note 2, p. 86.]

reflex, a feeling of excitation and tension arises, as we all know. The excitation, which has been unable to flow off along motor paths, now, inhibiting all other activity, spreads over the brain. This everyday example gives us the pattern of what happens when a psychical reflex, even the most complicated one, fails to occur. The excitement which we have discussed above [p. 205 f. n.] as characteristic of the emotion of revenge is in essentials the same. And we can follow the same process even up to the highest regions of human achievement. Goethe did not feel he had dealt with an experience till he had discharged it in creative artistic activity. This was in his case the preformed reflex belonging to affects, and so long as it had not been carried out the distressing increase of his excitation persisted.

Intracerebral excitation and the excitatory process in peripheral paths are of reciprocal magnitudes: the former increases if and so long as no reflex is released; it diminishes and disappears when it has been transformed into peripheral nervous excitation. Thus it seems understandable that no observable affect is generated if the idea that should have given rise to it immediately releases an abnormal reflex into which the excitation flows away as soon as it is generated. The 'hysterical conversion' is then complete. The original intracerebral excitation belonging to the affect has been transformed into the excitatory process in the peripheral paths. What was originally an affective idea now no longer provokes the affect but only the abnormal reflex.[1]

We have now gone a step beyond the 'abnormal expression of the emotions'. Hysterical phenomena (abnormal reflexes) do not seem to be ideogenic even to intelligent patients who are good observers, because the idea that gave rise to them is no longer coloured with affect and no longer marked out among

[1] I am anxious not to drive the analogy with an electrical system to death. In view of the totally different conditions it can scarcely illustrate the processes in the nervous system and can certainly not explain them. But I may once more recall the case in which, owing to excessively high tension, the insulation of the wires in a lighting system breaks down and a 'short circuit' occurs at some point in it. If electrical phenomena (such as overheating or sparking) occur at this point, the lamp to which the wire leads fails to light. In just the same way the affect fails to appear if the excitation flows away in an abnormal reflex and is converted into a somatic phenomenon.

other ideas and memories. They emerge as isolated hysterical phenomena, apparently without psychical roots.

What is it that determines the discharge of affect in such a way that one particular abnormal reflex is produced rather than some other? Our observations answer this question in many instances by showing that here again the discharge follows the 'path of least resistance' and takes place along those paths whose resistances have already been weakened by concurrent circumstances. This covers the case which we have already mentioned of a particular reflex being facilitated by already existing somatic illness. If, for instance, someone suffers often from cardiac pains, these will also be provoked by affects. Alternatively, a reflex may be facilitated by the fact that the muscular innervation concerned was deliberately intended at the moment at which the affect supervened. Thus Anna O. (in our first case history) tried, in her fright, to stretch out her right arm, which had gone to sleep owing to pressure against the back of the chair, in order to ward off the snake; and from that time on the tetanus of her right arm was provoked by the sight of any snake-like object. Or again (p. 40) in her emotion she brought her eyes forcibly together in order to read the hands of the watch, and thereupon a convergent squint became one of the reflexes of that affect. And so on.

This is due to the operation of simultaneity, which indeed governs our normal associations. Every sense-perception calls back into consciousness any other sense-perception that appeared originally at the same time. (Cf. the text-book example of the visual image of a sheep and the sound of its bleating, etc.) If the simultaneous affect was accompanied by an intense sense-impression, the latter is called up once more when the affect is renewed; and since it is a question of discharging excessively great excitation, the sense-impression emerges not as a recollection but as a hallucination. Almost all our case histories furnish instances of this. It is also what happened in the case of a woman who experienced a painful affect at a time when she was having violent toothache from periostitis, and who thenceforward suffered from infra-orbital neuralgia whenever the affect was renewed or even recollected [p. 178].

What we have here is the facilitation of abnormal reflexes

Benedikt [1894, 51 ff.].

ever-diminishing amount of excitation; and the recollection thus loses the capacity to contribute to the production of a somatic phenomenon. The facilitation of the abnormal reflex disappears and the *status quo ante* is thereby re-established.

The 'wearing-away' influences, however, are all of them effects of association, of thinking, of correction by reference to other ideas. This process of correction becomes impossible if the affective idea is withdrawn from 'associative contact'. When this happens the idea retains its whole quota of affect. Since at every renewal the whole sum of excitation of the original affect is liberated once more, the facilitation of the abnormal reflex that was started at the time is finally completed; or, if the facilitation was already complete, it is maintained and stabilized. The phenomenon of hysterical conversion is thus permanently established.

Our observations show two ways in which affective ideas can be excluded from association.

The first is 'defence', the deliberate suppression of distressing ideas which seem to the subject to threaten his happiness or his self-esteem. In his first paper on 'The Neuro-Psychoses of Defence' (1894a)[1] and in his case histories in the present volume, Freud has discussed this process, which undoubtedly possesses very great pathological significance. We cannot, it is true, understand how an idea can be deliberately repressed from consciousness. But we are perfectly familiar with the corresponding positive process, that of concentrating attention on an idea, and we are just as unable to say how we effect that. Ideas, then, from which consciousness is diverted, which are not thought about, are also withdrawn from the wearing-away process and retain their quota of affect undiminished.

We have further found that there is another kind of idea that remains exempt from being worn away by thought. This may happen not because one does not *want* to remember the idea, but because one *cannot* remember it: because it originally emerged and was endowed with affect in states in respect of which there is amnesia in waking consciousness—that is, in hypnosis or in states similar to it. The latter seem to be of the highest importance for the theory of hysteria and accordingly deserve a somewhat fuller examination.[2]

[1] [See footnote, p. 10.]

[2] When here and later on we speak of ideas that are currently present

(4) Hypnoid States

[illegible]

[illegible] embody an important truth.

[illegible] of them.

[illegible]

[illegible] affective excitation.

[illegible]

[illegible]

[illegible]

[illegible] ideas.

[illegible]

[illegible] reveries and that it was [illegible] established by an [illegible] which indeed [illegible] It seems [illegible] that this [illegible] good [illegible]

A great [illegible] states lead to absence of mind, but only a few [illegible] A person who is deep in a problem is also [illegible] a certain degree, and he has large groups [illegible] perception, and [illegible] But in such [illegible] mental work is carried on, and the excitation [illegible] such as conversion.

[illegible] are pathogenic; on the other hand, [illegible] with emotion and states of fatigue [illegible] dreams of a lover [illegible] concentration on the [illegible] and at last almost [illegible] idea and its affect remain alive, [illegible] between the [illegible] When [illegible] the whole mass of excitation is at the disposal of the suggested idea.

[illegible]

into a habitual reverie. This is perhaps one of the reasons why in the anamneses of hysteria we so often come across the two great pathogenic factors of being in love and sick-nursing. In the former, the subject's longing thoughts about his absent loved one create in him a 'rapt' state of mind, cause his real environment to grow dim, and then bring his thinking to a standstill charged with affect; while in sick-nursing the quiet by which the subject is surrounded, his concentration on an object, his attention fixed on the patient's breathing—all this sets up precisely the conditions demanded by many hypnotic procedures and fills the twilight state produced in this way with the affect of anxiety. It is possible that these states differ only quantitatively from true auto-hypnoses and that they pass over into them.

Once this has happened, the hypnosis-like state is repeated again and again when the same circumstances arise; and the subject, instead of the normal two conditions of mind, has three: waking, sleeping and the hypnoid state. We find the same thing happening when deep artificial hypnosis has been frequently brought on.

I cannot say whether spontaneous hypnotic states may also be generated without an affect intervening in this way, as a result of an innate disposition; but I consider it very probable. When we see the difference in susceptibility to artificial hypnosis both among healthy and sick people and how easily it is brought on in some, it seems reasonable to suppose that in such people it can also appear spontaneously. And a disposition for this is perhaps necessary before a reverie can turn into an auto-hypnosis. I am therefore far from attributing to all hysterical patients the generating mechanism which we have been taught by Anna O.

I speak of hypnoid states rather than of hypnosis itself because it is so difficult to make a clear demarcation of these states, which play such an important part in the genesis of hysteria. We do not know whether reveries, which were described above as preliminary stages of auto-hypnosis, may not themselves be able to produce the same pathological effect as auto-hypnosis and whether the same may not also be true of a protracted affect of anxiety. It is certainly true of fright. Since fright inhibits the flow of ideas at the same time at which an affective idea (of danger) is very active, it offers a complete

paradoxically, a reverie charged with affect; and since the recurrence of the affective idea, which is constantly being renewed, keeps on re-establishing this state of mind, 'hypnoid' fright comes into being, in which the conversion is either brought about or stabilized. Here we have the incubation stage of 'traumatic hysteria' in the strict sense of the words.

In view of the fact that states of mind which are so different, though they agree with one another in the most important respect, can be classed with auto-hypnosis, it seems desirable to adopt the expression 'hypnoid', which lays stress on this internal similarity. It sums up the view put forward by Moebius in the passage quoted above (p. 2[illegible]). Most of all, however, it points to autohypnosis itself, the importance of which in the genesis of hysterical phenomena rests on the fact that it makes conversion easier and protects (by amnesia) the converted ideas from wearing away—a protection which leads, ultimately, to an increase in the psychical splitting.

If a somatic symptom is caused by an idea and is repeatedly set going by it, we should expect that intelligent patients capable of self-observation would be conscious of the connection. They would know by experience that the somatic phenomenon appeared at the same time as the memory of a particular event. The underlying causal nexus is, it is true, unknown to them; but all of us always know what the idea is which makes us cry or laugh or blush, even though we have not the slightest understanding of the nervous mechanism of these ideogenic phenomena. Sometimes patients do really observe the connection and are conscious of it. For instance, a woman may say that her mild hysterical attack (trembling and palpitations, perhaps) comes from some great emotional disturbance and is repeated when, and only when, some event reminds her of it. But this is not the case with very many or indeed the majority of hysterical symptoms. Even intelligent patients are unaware that their symptoms arise as the result of an idea and regard them as physical phenomena on their own account. If it were otherwise the psychical theory of hysteria must already have reached a respectable age.

It would be plausible to believe that, though the symptoms in question were ideogenic in the first instance, the repetition of them has, to use Romberg's phrase (1840, 192), 'imprinted'

[illegible] We have seen that [illegible]

[illegible]

are operative.

Moreover, when we come to analyse [illegible]

It may perhaps be allowed to examine this difficult and obscure region rather more closely. The need to establish the meaning of the terminology that has been used may to some extent excuse the theoretical discussion which follows.

(4) Unconscious Ideas and Ideas Inadmissible to Consciousness—Splitting of the Mind

We call those ideas conscious which we are aware of. There exists in human beings the strange fact of self-consciousness. We are able to view and observe as though they were objects ideas that emerge in us and succeed one another. This does not happen always, since occasions for self-observation are rare. But the capacity for it is present in everyone, for every person can say: 'I thought this or that.' We describe as conscious those ideas which we observe as active in us, or which we should so observe if we attended to them. At any given moment of time there are very few of them; and if others besides these should be current at the time we should have to call them *unconscious* ideas.

It hardly seems necessary any longer to argue in favour of the existence of current ideas that are unconscious or subconscious.[1] They are among the commonest facts of everyday life. If I have forgotten to make one of my medical visits I have feelings of lively unrest. I know from experience what this feeling means: that I have forgotten something. I search my memories, in vain; I fail to discover the cause till suddenly, hours later perhaps, it emerges into consciousness. But I have been uneasy the whole time. Accordingly, the idea of the visit has been all the time operative, that is, has been present, but not in consciousness. Or again, a busy man may have been annoyed by something one morning. He is entirely absorbed by his office work; while he is doing it his conscious thoughts are fully occupied and he gives no thought to his annoyance. But his decisions are influenced by it and he may well say 'no' where he would otherwise have said 'yes'. So in spite of everything this memory is operative, that is, it is present. A great deal of what we describe as 'mood' comes from sources of this kind and from ideas that exist and are operative beneath the threshold of

[1] [See footnote, p. 45.]

of [illegible] Indeed the whole [illegible] [illegible] by [illegible] We [illegible] how where there is [illegible] [illegible] restrain [illegible] become weaker and [illegible] that the patient who now makes [illegible] in the presence of women was [illegible] prevented from [illegible] by [illegible] memories and [illegible] [illegible] [illegible] ideas which were [illegible] by the [illegible] was [illegible] which remained beneath the [illegible] [illegible] [illegible] [illegible] [illegible]

The [illegible] that are raised [illegible] [illegible] [illegible] seem for the most part to be [illegible] [illegible] [illegible] whether the [illegible] [illegible] [illegible]

objection.

[illegible] there seems to be [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] seems [illegible] [illegible] [illegible]

I have already [illegible] perhaps be [illegible] our [illegible] by our [illegible] that [illegible] [illegible] among other things, by the [illegible]

with regard to what they are like in their content, is unconscious.[1] When an idea immediately produces abnormal somatic consequences, this means that the excitation engendered by it flows out into the paths concerned in these consequences instead of, as would happen otherwise, becoming diffused in the brain; and precisely because this idea has physical consequences, because its sums of psychical stimuli have been converted into somatic ones, it loses the clarity which would otherwise have marked it out in the stream of ideas. Instead of this it is lost among the rest.

Suppose, for instance, that someone has had a violent affect during a meal and has not abreacted it. When subsequently he attempts to eat he is overtaken by choking and vomiting and these seem to him purely somatic symptoms. The hysterical vomiting continues for some considerable time. It disappears after the affect has been revived, described and reacted to under hypnosis. There can be no doubt that every attempt to eat called up the memory concerned. This memory started the vomiting but did not appear clearly in consciousness, because it was now without affect, whereas the vomiting absorbed the attention completely.

It is conceivable for the reason which I have just given that some patients never recognize as their causes ideas that release hysterical phenomena. But this fact — that ideas that have lost their affect owing to conversion are overlooked — cannot possibly explain why, in other cases, ideas that are far from being devoid of affect do not enter consciousness. Numerous examples of this are to be found in our case histories.

In patients like these we found that it was the rule for the emotional disturbance — apprehensiveness, angry irritability, grief — to precede the appearance of the somatic symptom or to follow it immediately, and to increase, either until it was cleared up by being given utterance or until the affect and the somatic phenomenon gradually disappeared again. Where the former happened the quality of the affect always

[1] Breuer seems here to be using the term 'affect' in a sense quite [illegible] throughout the present volume, though [illegible] 'pleasure' and 'unpleasure'. The same word [illegible] is used [illegible] in the [illegible] sense of an unpleasurable [illegible] feeling.

[illegible] physician.

[illegible] 'inadmissible to consciousness'.[1]

[illegible]

[illegible] after a rescue. Such subsequent [illegible] the memory of an [illegible] affect so far as [illegible] is concerned, but they leave the subconscious idea, which produced the symptoms, completely untouched.

Perhaps I may be allowed to quote another example. A young married woman was for some time very much worried about a much younger sister's future. As a result of this her period, which was usually regular, lasted for two weeks; she was tender in the left hypogastrium, and twice she found herself lying stiff on the floor, after coming out of a faint. There followed an ovarian neuralgia on the left side, with signs of a severe peritonitis. The absence of fever and a contracture of the left leg (and of her back) showed that the illness was a pseudo-peritonitis; and when a few years later the patient died and an autopsy was performed, all that was found was a 'microcystic degeneration' of both ovaries without any traces of an old peritonitis. The severe symptoms disappeared by degrees and left behind an ovarian neuralgia, a contracture of the muscles of the back, so that her trunk was as stiff as a board, and a contracture of the left leg. The latter was got rid of in hypnosis by direct suggestion. The contracture of her back was unaffected by this. Meanwhile, the younger sister's difficulties had been completely straightened out and all her fears on that score had vanished. But the hysterical phenomena, which could only have been derived from them, persisted unaltered. It was tempting to suppose that what we were faced by were changes in innervation, which had assumed an independent status and were no longer attached to the idea that had caused them. But after the patient had been compelled under hypnosis to tell the whole story up to the time when she had fallen ill with 'peritonitis'—which she did very unwillingly—she immediately sat up in bed without assistance, and the contracture of her back disappeared for ever. (Her ovarian neuralgia, whose origin was undoubtedly far older, remained unaffected.) Thus we see that her pathogenic anxious idea had persisted in active operation for months, and that it had been completely inaccessible to criticism by everyday events.

If we are obliged to recognize the existence of ideas which never enter consciousness and are not influenced by conscious thought, we shall have admitted that, even in such simple cases of hysteria as the one I have just

described, there is a splitting of the mind into two relatively independent portions. I do not assert that everything that we call hysterical has a splitting of this kind as its basis and necessary condition; but I do assert that 'the splitting of psychical activity which is so striking in the well-known cases in the form of "double conscience" is present to a rudimentary degree in every major hysteria', and that 'the liability and tendency to such a dissociation is the basic phenomenon of this neurosis'.[1]

But before entering into a discussion of this subject, I must add a comment with regard to the unconscious ideas which produce somatic effects. Many hysterical phenomena persist continuously for a long time, like the contracture in the case described above. Should we and may we suppose that during all that time the causative idea is perpetually active and currently present? I think so. It is true that in healthy people we see their psychical activity going forward to the accompaniment of a rapid change of ideas. But we find sufferers from severe melancholia immersed continuously for long periods in the same distressing idea, which is perpetually active and present to them. Indeed, we may well believe that even when a healthy person has a great care on his mind it is present all the time, since it governs his facial expression even when his consciousness is filled with other thoughts. But the part of psychical activity which is separated off in hysterical subjects and which we think of as filled with unconscious ideas is as a rule so scantily occupied by them and so inaccessible to the alternation of external impressions that it is easy to believe that a single idea can be permanently active in it.

If it seems to us, as it does to Binet and Janet, that what lies at the centre of hysteria is a splitting off of a portion of psychical activity, it is our duty to be as clear as possible on this subject. It is only too easy to fall into a habit of thought which assumes that every substantive has a substance behind it—which gradually comes to regard 'consciousness' as standing for some actual thing; and when we have become accustomed to make use metaphorically of spatial relations, as in the term

1 [This passage, which is in inverted commas in the original, [illegible] no exact reference is given. It may be a rendering of a sentence which will be found in italics on p. [illegible] of the 'Preliminary Communication'.]

[illegible]

But only on this condition.

[illegible]

[illegible] *De la suggestion* (Freud, 1888–9).]

and to a great extent based on [illegible] Between the [illegible] is as [illegible] what [illegible] Here we have a [illegible] in [illegible] working [illegible] dark- ness of the [illegible] which have now gained [illegible] indeed even [illegible] of the mind is manifest.

It may be [illegible] that the [illegible] of [illegible] and Janet [illegible] of [illegible] have [illegible] sub- [illegible] and which [illegible] have been [illegible] that [illegible] and [illegible] can never [illegible] he [illegible] Nevertheless there is [illegible] when the [illegible] in their functional capability.

[illegible]

[illegible] See above p. 46.

[illegible] self, in *Faust*, Part I (Scene 4).]

[illegible] in the more severe degrees of hysteria and that [illegible] seems to make a [illegible] theory [illegible] possible.

What then can be asserted or suggested with probability about the causes and origin of this phenomenon?

Janet, to whom the theory of hysteria owes so very much and with whom we are in agreement in most respects, has expressed a view on this point which we are [illegible].

[illegible]

[illegible]

[illegible] and the [illegible] of her understanding and judgement. Chess, which she played [illegible] was a favourite [illegible] and she [illegible] playing two games at a time [illegible] [illegible]

[illegible] capacity is similarly reduced.

[illegible] capacity.

But [illegible] degree of [illegible] and weakness of will as a protection against hysteria. Even if

[illegible] the mind is untenable.[1]

[illegible]

[1 [illegible] p. 103 ff.]

[illegible]

[illegible] patients.

[illegible] consciousness.

[illegible]

[1] [Horace, *Odes*, III, 1.]

during her ordinary consciousness. While she was in a stupor that lay [illegible] the [illegible] to her [illegible] her reverie and created a hypnoid state for which she has amnesia. This was repeated on different occasions and its ideational content gradually became richer and richer. But it continued to alternate with states of completely normal waking thought. After four months the hypnoid state gained entire control of the patient. The separate attacks ran into one another and thus an état de mal arose, an acute hysteria of the most severe type. This lasted for several months in various forms (the period of somnambulism); [illegible] and thereafter alternated once again with normal psychical behaviour. But even during her normal behaviour there was a persistence of somatic and psychical phenomena ([illegible] and changes in speech) of which in this case we know as a fact that they were based on ideas belonging to the hypnoid state. This proves that even during her normal behaviour [illegible] to the hypnoid state [illegible] was in existence and that the split in her mind persisted.

I have no second example to offer of a similar course of development. I think, however, that the case throws some light also on the growth of traumatic neuroses. During the first few days after the traumatic event, the state of hypnoid fright is repeated every time the event is recalled. While this state recurs more and more often, its intensity so diminishes that it no longer alternates with waking thought but only exists side by side with it. It now becomes continuous, and the somatic symptoms, which earlier were only present during the attack of fright, acquire a permanent existence. I can, however, only suppose that this is what happens, as I have never analysed a case of this kind.

Freud's observations and analyses show that the splitting of the mind can also be caused by [illegible] by the deliberate deflection of consciousness from distressing ideas. This, however, only happens in some people, to whom we must [illegible] a mental peculiarity. In normal people [illegible] or they are [illegible] sciousness. I cannot tell what the nature of this peculiarity is. I only venture to suggest that the assistance of the hypnoid [illegible]

[illegible] are driven. But, [illegible]

[illegible]

[illegible]

[illegible] and affective states.

achieved towards an understanding of hysteria. It seems to have been great in [illegible] and [illegible].

These discoveries have in the last [illegible] made it possible for what are [illegible] to be traced back to ideas which, however, are not discoverable in the patient's consciousness [illegible] this again. In the second place they have [illegible] and [illegible] hysterical attacks, in part at least, as being products of an [illegible] complex [illegible] but besides this, they have also explained some of the [illegible], and this [illegible] deserves a more [illegible] discussion.

It is true that unconscious ideas never, or only rarely and with difficulty, enter waking thought; but they influence it. They do so, first, [illegible] when, for instance, a patient is tormented by a [illegible] which is totally unintelligible and senseless, but whose meaning and motivation become clear under hypnosis. Further, they influence association by making certain ideas [illegible] than they would have been [illegible] from the [illegible] patients. When their [illegible] hand is repeatedly touched they [illegible] when they are told to name any number they like [illegible] the one corresponding to the number of times they have been touched. Again, unconscious ideas govern the patient's emotional tone, his state of feeling. When, in the course of unfolding her memories, Anna O. approached an event which had originally been bound up with a lively affect, the corresponding feeling made its appearance several days in advance and before the recollection appeared clearly even in her hypnotic consciousness.

This makes the patients' moods, their [illegible], their inexplicable, unreasonable changes of feeling [illegible] waking thought without [illegible] patients is indeed to a large extent determined by their [illegible] expectations, but the [illegible] they are thrown by trifles [illegible] if we reflect that the split-off mind acts like a sounding board

[illegible] the mere [illegible] of a [illegible]. Any event that provokes [illegible] [illegible] the whole [illegible] of these ideas [illegible] and the affect [illegible] any that would have [illegible].

I have spoken [illegible] whose psychical [illegible] in inverse ratio to the [illegible] of her [illegible] was [illegible] a peculiar kind of [illegible]. After each of her [illegible] absences [illegible] and these were [illegible] recurring [illegible] not know what she had thought [illegible] between her [illegible] and [illegible] between the [illegible] and the [illegible] was [illegible] that [illegible] was reduced, not on [illegible] unconscious. While she was in this state her waking thought was without energy. Her [illegible] was [illegible] and she seemed, as I have said, [illegible]. I believe that this was due to the fact that waking thought has less energy at its disposal if a great amount of psychical excitation is [illegible] by the unconscious.

If this state of things is not merely temporary, if the [illegible] itself [illegible] experience, as it was with Janet's [illegible] sensations [illegible] the body were [illegible] by the [illegible]. If this is the case, [illegible] the cerebral [illegible] weakness [illegible] innate as I have assumed [illegible] a few people of whom it could be said, as of [illegible] Bertrand de Born, that they never [illegible] Such a reduction in their psychical energy does make the majority of people weak-minded.

That weakness of mind caused by a splitting of the psyche seems [illegible] be a basis of a [illegible] characteristic of some [illegible]. I say 'some', since it is [illegible] are to be found people [illegible] as well.

By [illegible] we [illegible] in the first instance only an

[1] A famous troubadour about whom Uhland wrote a ballad.]

case of general abnormal ex[illegible][1] even though it is the [illegible] from the point of view of our present [illegible]

It seems to me therefore that the old 'reflex theory' of these [illegible] which [illegible] perhaps be better described [illegible] as [illegible] which form part of the empirical [illegible] [illegible] should not be [illegible] [illegible] [illegible] of the [illegible] than, where there is abnormal ex[illegible] [illegible] a reflex [illegible] by [illegible] We are [illegible] [illegible] changes, so [illegible] [illegible] [illegible] all cases.

[illegible] [illegible] and so [illegible] [illegible] [illegible] [illegible] has been [illegible]

[illegible] which we have been discussing seems [illegible] ex[illegible] [illegible] properties of many hysterical [illegible] [illegible] which is [illegible] by their nervous system when in a state of rest [illegible] [illegible] [illegible] [illegible] [illegible]

[1] Compare [illegible] of the [illegible] [See footnote, p. [illegible]]

[2] [See footnote, p. 15.]

[illegible]

stages of tabes.

[illegible]

* [Cf. a remark of Freud's, p. 258.]

in the first instance by some sensation in the eyes or face or by an uncomfortable article of [illegible] permanent unless they are [illegible] are very [illegible]

Nor can the [illegible]

We [illegible]

[illegible]

[illegible]

of the nervous system.

[illegible]

hysteria.

[illegible]

consciousness, and the affective ideas with which it is concerned that are fended off and thus become unconscious.

The tendency towards fending off what is sexual is further intensified by the fact that in young unmarried women sensual excitation has an admixture of anxiety, of fear of what is coming, what is unknown and half-suspected, whereas in normal and healthy young men it is an unmixed and aggressive instinct. The girl senses in Eros the terrible power which governs and decides her destiny and she is frightened by it. All the greater, then, is her inclination to look away and to repress from her consciousness the thing that frightens her.

Marriage brings fresh sexual traumas. It is surprising that the wedding night does not have pathogenic effects more frequently, since unfortunately what it involves is so often not an erotic seduction but a violation. But indeed it is not rare to find in young married women hysterias which can be traced back to this and which vanish if in the course of time sexual enjoyment emerges and wipes out the trauma. Sexual traumas also occur in the later course of many marriages. The case histories from whose publication we have been obliged to refrain include a great number of them—perverse demands made by the husband, unnatural practices, etc. I do not think I am exaggerating when I assert that *the great majority of severe neuroses in women have their origin in the marriage bed*.[1]

Certain sexual noxae, which consist essentially in insufficient satisfaction (*coitus interruptus*, *ejaculatio praecox*, etc.), result according to the discovery of Freud (1895b) not in hysteria but in anxiety neurosis. I am of opinion, however, that even in such cases the excitation of the sexual affect is quite frequently converted into hysterical somatic phenomena.

It is self-evident and it is also sufficiently proved by our observations that the non-sexual affects of fright, anxiety and anger lead to the development of hysterical phenomena. But it is perhaps worth while insisting again and again that the sexual

[1] It is a most unfortunate thing that clinical medicine ignores one of the most important of all the pathogenic factors or at least only hints at it delicately. This is certainly a subject in which the acquired knowledge of experienced physicians should be communicated to their juniors, who as a rule blindly overlook sexuality—at all events so far as their patients are concerned.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] mena come into being.

[illegible]

[illegible]

[illegible]

¹ ['Orgasmus.' In the first edition only this is misprinted 'Organismus.']

consciousness. Of the hysterical deliria in saints and nuns, continent women and well-brought-up children.

Since these states are so often nothing less than psychoses and are yet derived immediately and exclusively from hysteria, I cannot agree with Möbius's opinion that 'apart from the deliria attached to attacks, it is impossible to speak of an actual hysterical insanity' (1895, 18). In many cases these states constitute an insanity of this kind; and psychoses like these also recur in the further course of a hysteria. It is true that essentially they are nothing other than the psychotic stage of an attack, but since they last for months they can nevertheless hardly be described as attacks.

How does one of these acute hysterias arise? In the best-known case (Case History 1) it developed out of an accumulation of hypnoid attacks; in another case, where there was already a complicated hysteria present, it arose in association with a withdrawal of morphine. The process is for the most part completely obscure and awaits clarification from further observations.

Accordingly, we may apply to the hysterias which have been discussed here Möbius's pronouncement (ibid., 16): 'The essential change that occurs in hysteria is that the mental state of the hysterical patient becomes temporarily or permanently similar to that of a hypnotized subject.'

The persistence in the normal state of the hysterical symptoms that have arisen during the hypnoid state corresponds entirely to our experiences with post-hypnotic suggestion. But this already implies that complexes of ideas that are inadmissible to consciousness coexist with the trains of ideas that pursue a conscious course, that the splitting of the mind has taken place (p. 229). It seems certain that this can happen even without a hypnoid state, from the wealth of thoughts which have been fended off, repressed from consciousness but not suppressed. In one way or another there comes into existence a region of mental life—sometimes poor in ideas and rudimentary, sometimes more or less on a par with waking thought—our knowledge of which we owe, above all, to Binet and Janet. The splitting of the mind is the consummation of hysteria. I have shown above (Section 5) how it explains the principal characteristics of the disorder. One part of the patient's mind is in the hypnoid state, permanently, but with a varying degree of

weakness in his ideas, and is always prepared, whenever there is a lapse in waking thought, to assume control over the whole person (e.g. in an attack or delirium). This exists as it were as a powerful ally [illegible] the normal course of ideas, in two [illegible] of a system of exhaustion [illegible] the person's hypnoid state unknown [illegible] to normal association [illegible] consequence [illegible] hallucinations are introduced into the perceptual system and motor acts are innervated independently of the conscious will. The hypnoid mind is in the highest degree susceptible to conversion of affects and to suggestion; and thus fresh hysterical phenomena appear easily, which without the split in the mind would only have come about with great difficulty and under the pressure of repeated affects. The split-off mind is the devil with which the unsophisticated observation of early superstitious times believed that these patients were possessed. It is true that a spirit alien to the patient's waking consciousness holds sway in him; but the spirit is not in fact an alien one, but a part of his own.

The attempt that has been made here to make a synthetic construction of hysteria out of what we know of it to-day is open to the reproach of eclecticism, if such a reproach can be justified at all. There were so many formulations of hysteria, from the old 'reflex theory' to the 'dissociation of personality', which have had to find a place in it. But it can scarcely be otherwise. For so many excellent observers and acute minds have concerned themselves with hysteria. It is unlikely that any of their formulations was without a portion of the truth. A future exposition of the true state of affairs will certainly include them all and will merely combine all the one-sided views of the subject into a corporate reality. Eclecticism, therefore, seems to me nothing to be ashamed of.

But how far we still are to-day from the possibility of any such complete understanding of hysteria. With what uncertain strokes have its outlines been drawn in these pages, with what clumsy hypotheses have the gaping lacunas been concealed rather than bridged. Only one consideration is to some extent consoling: that this defect attaches and must attach to all physiological expositions of complicated psychical processes. We must always say of them what Theseus in *A Midsummer Night's Dream* says of tragedy: 'The best in this kind are but

shadows. And even the weakest is not without value if it honestly and modestly tries to hold on to the outlines of the shadows which the unknown real objects throw upon the wall. For then, in spite of everything, the hope is always justified that there may be some degree of correspondence and similarity between the real processes and our idea of them.

IV

THE PSYCHOTHERAPY OF HYSTERIA

(FREUD)

IV

THE PSYCHOTHERAPY OF HYSTERIA

(FREUD,

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[illegible]

[illegible]

(1)

[illegible]

a different grouping and interpretation of the facts already known to me at that time. It would be unjust if I were to try to lay too much of the responsibility for this development on my honoured friend Dr. Josef Breuer. For this reason the considerations which follow stand principally under my own name.

When I attempted to apply to a comparatively large number of patients Breuer's method of treating hysterical symptoms by an investigation and abreaction of them under hypnosis, I came up against two difficulties, in the course of dealing with which I was led to an alteration both in my technique and in my view of the facts. (1) I found that not everyone could be hypnotized who exhibited undoubted hysterical symptoms and who, it was highly probable, was governed by the same psychical mechanism. (2) I was forced to take up a position on the question of what, after all, essentially characterizes hysteria and what distinguishes it from other neuroses.

I will put off for the moment my account of how I got over the first difficulty and what I learnt from it. I will begin by describing the attitude I adopted in my daily practice towards the second problem. It is very hard to obtain a clear view of a case of neurosis before one has submitted it to a thorough analysis—an analysis which can only be brought about, in fact, by the use of Breuer's method; but a decision on the diagnosis and the form of therapy to be adopted has to be made before any such thorough knowledge of the case has been arrived at. The only course open to me, therefore, was to select for treatment by the cathartic method such cases as could be provisionally diagnosed as hysteria, which exhibited one or more of the stigmata or characteristic symptoms of hysteria. It then sometimes happened that in spite of the diagnosis of hysteria the therapeutic results turned out to be very scanty and that even analysis brought nothing significant to light. On other occasions again, I tried applying Breuer's method of treatment to neuroses which no one could have mistaken for hysteria, and I found that in that manner they could be influenced and indeed cleared up. I had this experience, for instance, with obsessional ideas, genuine obsessional ideas of the Westphal[1] type, in cases without a single trait which recalled hysteria.

[1] Westphal (1877) had given a detailed description of these.

of that investigation.

analysis (1910k.)

[illegible]

¹ [See footnote 1, p. 127.]

however, I claim in these pages for a therapy of the neuroses [illegible] has been confirmed by practitioners what I [illegible] to [illegible] at least [illegible] later [illegible]. But I am [illegible] I think [illegible] following remarks by way of comparison and explanation.

(1) I do not claim that I have actually got rid of all the hysterical symptoms that I have undertaken to treat by the cathartic method. But it is my opinion that the obstacles have lain in the personal circumstances of the patients and have not been due to any question of theory. I am justified in leaving these unsuccessful cases out of account in arriving at a judgement, just as a surgeon disregards cases of death which occur under anaesthesia, owing to post-operative haemorrhage, accidental sepsis, etc., when he is making a decision about a new technique. When later on I come to deal with the difficulties and drawbacks of the procedure, I shall return to a consideration of failures from this source. [See p. 301 ff.]

(2) The cathartic method is not to be regarded as worthless because it is a symptomatic and not a causal one. For a causal therapy is as a rule in fact only a prophylactic one; it brings to a halt any further effects of the noxious agency, but does not therefore necessarily get rid of the results which that agency has already brought about. As a rule a second phase of treatment is required to perform this latter task, and in cases of hysteria the cathartic method is quite invaluable for this purpose.

(3) Where a period of hysterical production, an acute hysterical paroxysm, has been overcome and all that is left over are hysterical symptoms in the shape of residual phenomena, the cathartic method suffices for every indication and brings about complete and permanent successes. A favourable constellation of this kind for therapy is not seldom to be found precisely in the region of sexual life, owing to the wide oscillations in the intensity of sexual needs and the complications of the conditions necessary in order to bring about a sexual trauma. Here the cathartic method does all that can be asked of it, for the physician cannot set himself the task of altering a constitution such as the hysterical one. He must content himself with getting rid of the troubles to which such a constitution is inclined and which may arise from it with the concurrence of external circumstances. He will feel satisfied if the patient

operative.

1 [See footnote, p. 212.]

patients by means of prolonged concentration and occasional 'chimney-sweeping' (p. 30).

It remains for me to mention the apparent contradiction between the admission that not all hysterical symptoms are psychogenic and the assertion that they can all be got rid of by a psychotherapeutic procedure. The solution lies in the fact that some of these non-psychogenic symptoms (stigmata, for instance) are, it is true, indications of illness, but cannot be described as ailments; and consequently it is not of practical importance if they persist after the successful treatment of the illness. As regards other such symptoms, it seems to be the case that in some roundabout way they are carried off along with the psychogenic symptoms, just as, perhaps, in some roundabout way they are after all dependent on a psychical causation.

I must now consider the difficulties and disadvantages of our therapeutic procedure, so far as they do not become obvious to everyone from the case histories reported above or from the remarks on the technique of the method which follow later. I will enumerate and indicate these difficulties rather than elaborate them.

The procedure is laborious and time-consuming for the physician. It presupposes great interest in psychological happenings, but personal concern for the patients as well. I cannot imagine bringing myself to delve into the psychical mechanism of a hysteria in anyone who struck me as low-minded and repellent, and who, on closer acquaintance, would not be capable of arousing human sympathy; whereas I can keep the treatment of a tabetic or rheumatic patient apart from personal approval of this kind. The demands made on the patient are not less. The procedure is not applicable at all below a certain level of intelligence, and it is made very much more difficult by any trace of feeble-mindedness. The complete consent and complete attention of the patients are needed, but above all their confidence, since the analysis invariably leads to the disclosure of the most intimate and secret psychical events. A good number of the patients who would be suitable for this form of treatment abandon the doctor as soon as the suspicion begins to dawn on them of the direction in which the investigation is leading. For patients such as these the doctor has remained a

In view of the difference that I usually find between my judgement on a case of neurosis *before* and *after* an analysis of this kind, I am almost compelled to regard an analysis as essential for the understanding of a neurotic illness. Moreover, I have adopted the habit of combining cathartic psychotherapy with a rest-cure which can if need be extended into a complete treatment of feeding-up on Weir Mitchell lines. This gives me the advantage of being able on the one hand to avoid the very disturbing introduction of new psychical impressions during a psychotherapy, and on the other hand to remove the boredom of a rest-cure, in which the patients not infrequently fall into the habit of harmful day-dreaming. It might be expected that the often very considerable psychical work imposed on the patients during a cathartic treatment, and the excitations resulting from the reproduction of traumatic experiences, would run counter to the intentions of the Weir Mitchell rest-cure and would hinder the successes which we are accustomed to see it bring about. But the opposite is in fact the case. A combination such as this between the Breuer and Weir Mitchell procedures produces all the physical improvement that we expect from the latter, as well as having a far-reaching psychical influence such as never results from a rest-cure without psychotherapy.[1]

(2)

I will now return to my earlier remark [p. 256] that in my attempts to apply Breuer's method more extensively I came upon the difficulty that a number of patients could not be hypnotized, although their diagnosis was one of hysteria and it seemed probable that the psychical mechanism described by us operated in them. I needed hypnosis to extend their memory in order to find the pathogenic recollections which were not present in their ordinary consciousness. I was obliged therefore either to give up the idea of treating such patients or to endeavour to bring about this extension in some other way.

I was as little able as anyone else to explain why one person can be hypnotized and another not, and thus I

[1] Weir Mitchell's book on *The Treatment of Certain Forms of Neurasthenia and Hysteria* had been favourably reviewed by Freud [illegible]

could not adopt a causal method of meeting the difficulty. I noticed, however, that in some patients the obstacle lay still further back: they refused even any *attempt* at hypnosis. The idea then occurred to me one day that the two cases might be identical and that both might signify an unwillingness; that people who were not hypnotizable were people who had a psychical objection to hypnosis, whether their objection was expressed as unwillingness or not. I am not clear in my mind whether I can maintain this view.

The problem was, however, how to bypass hypnosis and yet obtain the pathogenic recollections. This I succeeded in doing in the following manner.

When, at our first interview, I asked my patients if they remembered what had originally occasioned the symptom concerned, in some cases they said they knew nothing of it, while in others they brought forward something which they described as an obscure recollection and could not pursue further. If, following the example of Bernheim when he awoke in his patients impressions from their somnambulistic state which had ostensibly been forgotten, I now became insistent—if I assured them that they did know it, that it would occur to their minds,—then, in the first cases, something did occur to them, and, in the others, their memory went a step further. After this I became still more insistent; I told the patients to lie down and deliberately close their eyes in order to 'concentrate'—all of which had at least some resemblance to hypnosis. I then found that without any hypnosis new recollections emerged which went further back and which probably related to our topic. Experiences like this made me think that it would in fact be possible for the pathogenic groups of ideas, that were after all certainly present, to be brought to light by mere insistence; and since this insistence involved effort on my part and so suggested the idea that I had to overcome a resistance, the situation led me at once to the theory that *by means of my psychical work I had to overcome a psychical force in the patients which was opposed to the pathogenic ideas becoming conscious (being remembered).* A new understanding seemed to open before my eyes when it occurred to me that this must no doubt be the same psychical force that had played a part in the generating of the hysterical symptom and had at that time prevented the pathogenic idea from becoming conscious. What

[illegible]

demonstrated.

[illegible]

[illegible]

patient's not knowing was in fact a 'not wanting to know'—a not wanting which could be to a greater or less extent conscious. The task of the therapist, therefore, lies in overcoming by his psychical work this resistance to association. He does this in the first place by 'insisting', by making use of psychical compulsion to direct the patient's attention to the ideational traces of which he is in search. His efforts, however, are not exhausted by this, but, as I shall show, they take on other forms in the course of an analysis and call in other psychical forces to assist them.

I must dwell on the question of insistence a little longer. Simple assurances such as 'of course you know it', 'tell me all the same', 'you'll think of it in a moment' do not carry us very far. Even with patients in a state of 'concentration' the thread breaks off after a few sentences. It should not be forgotten, however, that it is always a question here of a quantitative comparison, of a struggle between motive forces of different degrees of strength or intensity. Insistence on the part of a strange doctor who is unfamiliar with what is happening is not powerful enough to deal with the resistance to association in a serious case of hysteria. We must think of stronger means.

In these circumstances I make use in the first instance of a small technical device. I inform the patient that, a moment later, I shall apply pressure to his forehead, and I assure him that, all the time the pressure lasts, he will see before him a recollection in the form of a picture or will have it in his thoughts in the form of an idea occurring to him; and I pledge him to communicate this picture or idea to me, whatever it may be. He is not to keep it to himself because he may happen to think it is not what is wanted, not the right thing, or because it would be too disagreeable for him to say it. There is to be no criticism of it, no reticence, either for emotional reasons or because it is judged unimportant. Only in this manner can we find what we are in search of, but in this manner we shall find it infallibly. Having said this, I press for a few seconds on the forehead of the patient as he lies in front of me; I then leave go and ask quietly, as though there were no question of a disappointment: 'What did you see?' or 'What occurred to you?'[1]

This procedure has taught me much and has also invariably achieved its aim. To-day I can no longer do without it. I am

[1] [See p. 110 and footnote.]

[illegible]

taking place in them.[1]

[illegible]

ated in a footnote to that passage.]

[illegible]

[illegible] the pathogenic [illegible] be found. In [illegible] where [illegible] pressure was not [illegible] the pathogenic [illegible] in any case be [illegible] next and [illegible] up [illegible] the [illegible] first [illegible] the pressure may [illegible] never been [illegible] It [illegible] starting-point.

[illegible] pressure of the hand [illegible] of the [illegible] of his symptoms.

I [illegible] a few [illegible] brought about by this [illegible] procedure

[illegible]
form of mundane therapy?

[illegible]

pear in these rooms and between these people followed one after the other: they were accompanied by the disappointment of the governess, who left in order to get married. I could make nothing at all of these reminiscences. I could not establish any connection between them and the aetiology of the attacks. Various circumstances showed, however, that they belonged to the same period at which the attacks first appeared. But before I was able to proceed with the analysis I had occasion to talk to a colleague who many years before had been the family's doctor. He gave me the following information. At the time at which he was treating the girl, who was a very immature girl and very well developed physically, for her first attacks he was struck by the excessive affectionateness of the relation between her and the governess who was at that time in the house. He became suspicious and induced the girl's mother to keep an eye on this relationship. After a short time the old lady was able to report to him that the governess was in the habit of visiting the child in bed at night and that after such nights the child was invariably found next morning in an attack. They did not hesitate after this to arrange for the quiet removal of this corrupter of youth. The children and their mother were encouraged to believe that the governess had gone away to get married. My therapy, which was immediately successful, consisted in giving the young woman the information I had received.

The revelations which one obtains through the procedure of pressing sometimes appear in a very remarkable light and in circumstances which make the assumption of there being an unconscious intelligence even more tempting. Thus I remember a lady who had suffered for many years from obsessions and phobias and who referred me to her childhood for the genesis of her illness but was also quite unable to say what might be to blame for it. She was frank and intelligent and she put up only a remarkably small conscious resistance. (I may remark in parenthesis that the psychical mechanism of obsessions has a very great deal of inner kinship with hysterical symptoms and that the technique of analysis is the same for both.) When I asked this lady whether she had seen anything or had any recollection under the pressure of my hand, she replied: "Neither the one nor the other, but a word has suddenly occurred to me." "A single word?" "Yes, but it sounds too silly."

Say at the same time: 'Concierge.' Nothing else. I pressed a second time and once more an isolated word shot through her mind: 'Night-gown.' I saw now that this was a new sort of method of answering, and by pressing repeatedly I brought out what seemed to be a meaningless series of words: 'Concierge'—'night-gown'—'bed'—'town'—'farm-cart.' 'What does all this mean?' I asked. She reflected for a moment and then the following thought occurred to her: 'It must be the story that has just come into my head. When I was ten years old and my next elder sister was twelve, she went raving mad one night and had to be tied down and taken into the town on a farm-cart. I remember perfectly that it was the concierge who overpowered her and afterwards went with her to the asylum as well.' We pursued this method of investigation and our oracle produced another series of words, which, though we were not able to interpret all of them, made it possible to continue this story and lead on from it to another one. Soon, moreover, the meaning of this reminiscence became clear. Her sister's illness had made such a deep impression on her because the two of them shared a secret; they slept in one room and on a particular night they had both been subjected to sexual assaults by a certain man. The mention of this sexual trauma in the patient's childhood revealed not only the origin of her first obsessions but also the trauma which subsequently produced the pathogenic effects.

The peculiarity of this case lay only in the emergence of isolated key-words which we had to work into sentences; for the appearance of disconnectedness and incoherence which characterized the words emitted in this oracular fashion applies equally to the complete ideas and scenes which are normally produced under my pressure. When these are followed up, it invariably turns out that the apparently disconnected reminiscences are closely linked in thought and that they lead quite straight to the pathogenic factor we are looking for. For this reason I am glad to recall a case of analysis in which my confidence in the procedure and pressure were first put to a hard test but afterwards brilliantly justified.

A very intelligent and apparently happy young married woman had consulted me about an obstinate pain in her abdomen which was resistant to treatment. I recognized that the pain was situated in the abdominal wall and must be

the sun from her. I had known for some time that what I had to deal with were allegories and at once asked the meaning of this last picture. She answered without hesitation: 'The sun is perfection, the ideal, and the grating represents my weaknesses and faults which stand between me and the ideal.' 'Are you reproaching yourself, then? Are you dissatisfied with yourself?' 'Yes indeed.' 'Since when?' 'Since I have been a member of the Theosophical Society and have been reading its publications. I always had a low opinion of myself.' 'What has made the strongest impression on you recently?' 'A translation from the Sanskrit which is just now coming out in instalments.' A minute later I was being initiated into her mental struggles and her self-reproaches, and was hearing about a small episode which gave rise to a self-reproach—an occasion on which what had previously been an organic pain now for the first time appeared as the consequence of the conversion of an excitation. The pictures which I had first taken for phosphenes were symbols of trains of thought influenced by the occult and were perhaps actually emblems from the title-pages of occult books.

Hitherto I have been so warm in my praises of the achievements of pressure as an auxiliary procedure, and I have the whole time so greatly neglected the aspect of defence or resistance, that I may no doubt have created an impression that this little device has put us in a position to master the psychical obstacles to a cathartic treatment. But to believe this would be to make a serious mistake. Gains of this kind, so far as I can see, are not to be looked for in treatment. Here, as elsewhere, a large change requires a large amount of work. The procedure by pressure is no more than a trick for temporarily taking unawares an ego which is eager for defence. In all fairly serious cases the ego recollects its aims once more and proceeds with its resistance.

I must mention the different forms in which this resistance appears. One is that as a rule the pressure procedure fails on the first or second occasion. The patient then declares, very disappointedly: 'I expected something would occur to me, but all I thought was how intently I was expecting it. Nothing came.' The fact of the patient putting himself on his guard like this does not yet amount to an obstacle. We can say in reply: 'It's precisely because you were too curious; it will work

resistance. And now to our work. It is remarkable how often patients, even the most docile and intelligent, can completely forget their undertaking, though they had agreed to it beforehand. They promised to say whatever occurred to them under the pressure of my hand, irrespective of whether it seemed to them relevant or not, and whether it was agreeable to them to say it or not—that is, without selecting it and without being influenced by criticism or affect. But they do not keep this promise; it is evidently beyond their strength to do so. The work keeps on coming to a stop and they keep on maintaining that this time nothing has occurred to them. We must not believe what they say, we must always assume, and tell them, too, that they have kept something back because they thought it unimportant or found it distressing. We must insist on this, we must repeat the pressure and represent ourselves as infallible, till at last we are really told something. The patient then adds: 'I could have said that to you the first time.' 'Why didn't you say it?' 'I couldn't believe it could be that. It was only when it came back every time that I made up my mind to say it.' Or else: 'I hoped it wouldn't be that of all things. I could well do without saying that. It was only when it refused to be repressed that I saw I shouldn't be let off.' Thus after the event the patient betrays the motives for a resistance which he refused to admit to begin with. He is evidently quite unable to do anything but put up resistance.

This resistance often conceals itself behind some remarkable excuses. 'My mind is distracted to-day; the clock or the piano in the next room is disturbing me.' I have learnt to answer such remarks: 'Not at all. You have at this moment come up against something that you had rather not say. It won't do you any good. Go on thinking about it.' The longer the pause between my hand's pressure and the patient's beginning to speak, the more suspicious I become and the more it is to be feared that the patient is re-arranging what has occurred to him and is mutilating it in his reproduction of it. An important piece of information is often announced as being a redundant accessory, like an opera prince disguised as a beggar. 'Something has occurred to me now, but it has nothing to do with the subject. I'm only telling it you because you want to know everything.' Accompanying words such as these usually introduce the long-sought solution. I always prick up my ears when I

that has been done, the picture vanishes, like a ghost that has been laid.

It is of course of great importance for the progress of the analysis that one should always turn out to be in the right vis-à-vis the patient, otherwise one would always be dependent on what he chose to tell one. It is therefore consoling to know that the pressure technique in fact never fails, apart from a single case, which I shall have to discuss later (p. 301 f.), but of which I can at once say that it corresponds to a particular motive for resistance. It can of course happen that one makes use of the procedure in circumstances in which there is nothing for it to reveal. For instance, we may ask for the further aetiology of a symptom when we already have it complete before us, or we may investigate the psychical genealogy of a symptom, such as a pain, which is in fact a somatic one. In such cases the patient will equally assert that nothing has occurred to him and his assertion will be in the right. We can avoid doing the patient an injustice if we make it quite a general rule all through the analysis to keep an eye on his facial expression as he lies quietly before us. We can then learn to distinguish without any difficulty the restful state of mind that accompanies the real absence of a recollection from the tension and signs of emotion with which he tries to disavow the emerging recollection, in obedience to defence. Moreover, experiences like these make it possible to use the pressure technique for purposes of differential diagnosis.

Thus even with the assistance of the pressure technique the work is by no means easy. The one advantage that we have gained is that we learn from the results of this procedure the direction in which we have to conduct our enquiries and the things that we have to insist upon to the patient. With some cases this suffices. The principal point is that I should guess the secret and tell it to the patient straight out; and he is then as a rule obliged to abandon his rejection of it. In other cases more is required. The patient's persisting resistance is indicated by the fact that connections are broken, that solutions are not forthcoming, that the pictures recollected are indistinct and incomplete. Looking back from a later period of an analysis to an earlier one, we are often astonished to realize in what a mutilated manner all the ideas and scenes emerged which we extracted from the patient by the procedure of pressing. Precisely the essential

elements of the picture were missing—its relation to the main contents of his thoughts—and that is why it remained unintelligible.

I will give one or two examples of the way in which a censoring of this kind operates when pathogenic recollections first emerge. For instance, the patient sees the upper part of a woman's body with the dress not properly fastened—out of carelessness, it seems. It is not until much later that he fits a head to this torso and thus reveals a particular person and his relation to her. Or he brings up a reminiscence from his childhood of two boys. What they look like is quite obscure to him, but they are said to have been guilty of some misdeed. It is not until many months later and after the analysis has made great advances that he sees this reminiscence once more and recognizes himself in one of the children and his brother in the other.

What means have we at our disposal for overcoming this continual resistance? Few, but they include almost all those by which one man can ordinarily exert a psychical influence on another. In the first place, we must reflect that a psychical resistance, especially one that has been in force for a long time, can only be resolved slowly and by degrees, and we must wait patiently. In the next place, we may reckon on the intellectual interest which the patient begins to feel after working for a short time. By explaining things to him, by giving him information about the marvellous world of psychical processes into which we ourselves only gained insight by such analyses, we make him himself a collaborator, induce him to regard himself with the objective interest of an investigator, and thus push back his resistance, resting as it does on an affective basis. But lastly—and this remains the strongest lever—we must endeavour, after we have discovered the motives for his defence, to deprive them of their value or even to replace them by more powerful ones. This no doubt is where it ceases to be possible to state psychotherapeutic activity in formulas. One works to the best of one's power, as an elucidator (where ignorance has given rise to fear), as a teacher, as the representative of a freer or superior view of the world, as a father confessor who gives absolution, as it were, by a continuance of his sympathy and respect after the confession has been made. One tries to give the patient human assistance, so far as this is allowed by the

capacity of one's own personality and by the amount of sympathy that one can feel for the particular case. It is an essential precondition for such psychical activity that we should have more or less divined the nature of the case and the motives of the defence operating in it, and fortunately the technique of insistence and pressure takes us as far as this. The more such riddles we have already solved, the easier we may find it to guess a new one and the sooner we shall be able to start on the truly curative psychical work. For it is well to recognize this clearly: the patient only gets free from the hysterical symptom by reproducing the pathogenic impressions that caused it and by giving utterance to them with an expression of affect, and thus the therapeutic task *consists solely in inducing him to do so*; and when once this task has been accomplished there is nothing left for the physician to correct or to remove. Whatever may be required for this purpose in the way of counter-suggestions has already been expended during the struggle against the resistance. The situation may be compared with the unlocking of a locked door, after which opening it by turning the handle offers no further difficulty.

Besides the intellectual motives which we mobilize to overcome the resistance, there is an affective factor, the personal influence of the physician, which we can seldom do without, and in a number of cases the latter alone is in a position to remove the resistance. The situation here is no different from what it is elsewhere in medicine and there is no therapeutic procedure of which one may say that it can do entirely without the co-operation of this personal factor.

(3)

In view of what I have said in the preceding section about the difficulties of my technique, which I have unsparingly exposed—I brought them together, incidentally, from the severest cases; things often turn out very much more convenently—in view of all this, then, everyone will no doubt feel inclined to ask whether it would not be more expedient, instead of putting up with all these troubles, to make a more energetic use of hypnosis or to restrict the use of the cathartic method to patients who can be put under deep hypnosis. As regards the latter proposal I should have to answer that in that

Anna O.'s case history in fact shows no sign of any such resistance.

I regard this distinction as so important that, on the strength of it, I willingly adhere to this hypothesis of there being a hypnoid hysteria. Strangely enough, I have never in my own experience met with a genuine hypnoid hysteria. Any that I took in hand has turned into a defence hysteria. It is not, indeed, that I have never had to do with symptoms which demonstrably arose during dissociated states of consciousness and were obliged for that reason to remain excluded from the ego. This was sometimes so in my cases as well; but I was able to show afterwards that the so-called hypnoid state owed its separation to the fact that in it a psychical group had come into effect which had previously been split off by defence. In short, I am unable to suppress a suspicion that somewhere or other the roots of hypnoid and defence hysteria come together, and that there the primary factor is defence. But I can say nothing about this.

My judgement is for the moment equally uncertain as regards 'retention hysteria',[1] in which the therapeutic work is supposed equally to proceed without resistance. I had a case which I looked upon as a typical retention hysteria and I rejoiced in the prospect of an easy and certain success. But this success did not occur, though the work was in fact easy. I therefore suspect, though once again subject to all the reserve which is proper to ignorance, that at the basis of retention hysteria, too, an element of defence is to be found which has forced the whole process in the direction of hysteria. It is to be hoped that fresh observations will soon decide whether I am running the risk of falling into one-sidedness and error in thus favouring an extension of the concept of defence to the whole of hysteria.

I have dealt so far with the difficulties and technique of the cathartic method, and I should like to add a few indications as to the form assumed by an analysis when this technique is adopted. For me this is a highly interesting subject, but I cannot expect it to arouse similar interest in others, who have not yet carried out an analysis of this kind. I shall, it is true, once more be talking about the technique, but this time it

[1] [Cf. above, p. 211 and footnote.]

[illegible] already [illegible] of the forces for which we cannot but hold the patients responsible and which must be partly the same in a [illegible] hysteria [illegible] the [illegible] I have [illegible] as [illegible] I [illegible] part of my [illegible] with the [illegible] of [illegible] which will be revealed [illegible] it may one day [illegible] a [illegible] as [illegible]

The first and most powerful [illegible] impression [illegible] ing [illegible] is [illegible] that the pathogenic psychical material which has ostensibly been forgotten, which is not at the ego's disposal and which plays no part in association and memory, nevertheless in some fashion lies ready to hand and in correct and proper order. It is only a question of removing the resistances that bar the way to the material. In other respects this material is known,[1] in the same way in which we are able to know anything; the correct connections between the separate ideas and between them and the non-pathogenic ones, which are frequently remembered, are in existence; they have been completed at some time or other and are stored up in the memory. The pathogenic psychical material appears to be the property of an intelligence which is not necessarily inferior to that of the normal ego. The appearance of a second personality is often presented in the most deceptive manner.

Whether this impression is justified, or whether in thinking this we are not dating back to the period of the illness an arrangement of the psychical material which in fact was made after recovery—these are questions which I should prefer not to discuss as yet, and not in these pages. The observations made during such analyses can in any case be most conveniently and clearly described if we regard them from the position that we are able to assume after recovery for the purpose of surveying the case as a whole.

As a rule, indeed, the situation is not as simple as we have represented it in particular cases—for instance, where there is only a single symptom, which has arisen from one major trauma. We do not usually find a single hysterical symptom, but a number of them, partly independent of one another and partly linked together. We must not expect to meet with a single

[1] [illegible] in the [illegible] [illegible] sense.]

traumatic memory and a single pathogenic idea as its nucleus, we must be prepared for more or less extensive successions of traumas and concatenations of pathogenic trains of thought. A mono-symptomatic traumatic hysteria is, as it were, an elementary organism, a unicellular creature, as compared with the complex structure of such comparatively severe[1] neuroses as we usually meet with.

The psychical material in such cases of hysteria presents itself as a structure in several dimensions which is stratified in at least three different ways. (I hope I shall presently be able to justify this pictorial mode of expression.) To begin with there is a nucleus consisting in memories of events or trains of thought in which the traumatic factor has culminated or the pathogenic idea has found its purest manifestation. Round this nucleus we find what is often an incredibly profuse amount of other mnemic material, which has to be worked through in the analysis and which is, as we have said, arranged in a threefold order.

In the first place there is an unmistakable linear chronological order which obtains within each separate theme. As an example of this I will merely quote the arrangement of the material in Breuer's analysis of Anna O. Let us take the theme of becoming deaf, of not hearing. This was differentiated according to seven sets of determinants, and under each of these seven headings ten to over a hundred individual memories were collected in chronological series (p. 36). It was as though we were examining a dossier that had been kept in good order. The analysis of my patient Emmy von N. contained similar files of memories though they were not so fully enumerated and described. These files form a quite general feature of every analysis and their contents always emerge in a chronological order which is as infallibly trustworthy as the succession of days of the week or names of the month in a mentally normal person. They make the work of analysis more difficult by the peculiarity that, in reproducing the memories, they reverse the order in which these originated. The freshest and newest experience in the file appears first, as an outer cover, and last of all comes the experience with which the series in fact began.

I have described such groupings of similar memories into

[1] [illegible] 'comparatively severe' [illegible] the first edition [illegible] only [illegible] 'severe' in all later editions.]

of memories arranged in linear sequences like a file of documents, a packet, etc., and constituting 'themes'. These themes exhibit a second kind of arrangement. Each of them is—I cannot express it in any other way—stratified concentrically round the pathogenic nucleus. It is not hard to say what produces this stratification, what diminishing or increasing magnitude is the basis of this arrangement. The contents of each particular stratum are characterized by an equal degree of resistance, and that degree increases in proportion as the strata are nearer to the nucleus. Thus there are zones within which there is an equal degree of modification of consciousness, and the different themes extend across these zones. The most peripheral strata contain the memories (or files), which, belonging to different themes, are easily remembered and have always been clearly conscious. The deeper we go the more difficult it becomes for the emerging memories to be recognized, till near the nucleus we come upon memories which the patient disavows even in reproducing them.

It is this peculiarity of the concentric stratification of the pathogenic psychical material which, as we shall hear, lends to the course of these analyses their characteristic features. A third kind of arrangement has still to be mentioned—the most important, but the one about which it is least easy to make any general statement. What I have in mind is an arrangement according to thought-content, the linkage made by a logical thread which reaches as far as the nucleus and tends to take an irregular and twisting path, different in every case. This arrangement has a dynamic character, in contrast to the morphological one of the two stratifications mentioned previously. While these two would be represented in a spatial diagram by a continuous line, curved or straight, the course of the logical chain would have to be indicated by a broken line which would pass along the most roundabout paths from the surface to the deepest layers and back, and yet would in general advance from the periphery to the central nucleus, touching at every intermediate halting-place—a line resembling the zig-zag line in the solution of a Knight's Move problem, which cuts across the squares in the diagram of the chess-board.

I must dwell for a moment longer on this last comparison, in order to emphasize a point in which it does not do justice to the

characteristic of the subject of the conversation. The logical chain corresponds not only to a zig-zag twisted line, but rather to a ramifying system of lines and more particularly to a converging one. It contains nodal points at which two or more threads meet and thereafter proceed as one; and as a rule several threads which run independently, or which are connected at various points by side-paths, debouch into the nucleus. To put this in other words, it is very remarkable how often a symptom is determined in several ways, is 'overdetermined'.[1]

My attempt to demonstrate the organization of the pathogenic psychical material will be complete when I have introduced one more complication. For it can happen that there is more than one nucleus in the pathogenic material—if, for instance, we have to analyse a second outbreak of hysteria which has an aetiology of its own but is nevertheless connected with a first outbreak of acute hysteria which was got over years earlier. It is easy to imagine, if this is so, what additions there must be to the strata and paths of thought in order to establish a connection between the two pathogenic nuclei.

I shall now make one or two further remarks on the picture we have just arrived at of the organization of the pathogenic material. We have said that this material behaves like a foreign body, and that the treatment, too, works like the removal of a foreign body from the living tissue. We are now in a position to see where this comparison fails. A foreign body does not enter into any relation with the layers of tissue that surround it, although it modifies them and necessitates a reactive inflammation in them. Our pathogenic psychical group, on the other hand, does not admit of being cleanly extirpated from the ego. Its external strata pass over in every direction into portions of the normal ego; and, indeed, they belong to the latter just as much as to the pathogenic organization. In analysis the boundary between the two is fixed purely conventionally, now at one point, now at another, and in some places it cannot be laid down at all. The interior layers of the pathogenic organization are increasingly alien to the ego, but once more without there being any visible boundary at which the pathogenic material begins. In fact the pathogenic organization does not behave like a foreign body, but far more like an infiltrate. In this simile the resistance must be regarded as what is infiltrating.

[1] ['Überdeterminiert'. See footnote, p. [illegible].]

[illegible] cut off

[illegible]

us, namely, that *it is quite hopeless to try to penetrate directly to the nucleus of the pathogenic organization*. Even if we could ourselves guess it, the patient would not know what to do with the explanation offered to him and would not be psychologically changed by it.

There is nothing for it but to keep at first to the periphery of the psychical structure. We begin by getting the patient to tell us what he knows and remembers, while we are at the same time already directing his attention and overcoming his slighter resistances by the use of the pressure procedure. Whenever we have opened a new path by thus pressing on his forehead, we may expect him to advance some distance without fresh resistance.

After we have worked in this way for some time, the patient begins as a rule to co-operate with us. A great number of reminiscences now occur to him, without our having to question him or set him tasks. What we have done is to make a path to an inner stratum within which the patient now has spontaneously at his disposal material that has an equal degree of resistance attaching to it. It is best to allow him for a time to reproduce such material without being influenced. It is true that he himself is not in a position to uncover important connections, but he may be left to clear up material lying within the same stratum. The things that he brings up in this way often seem disconnected, but they offer material which will be given point when a connection is discovered later on.

Here we have in general to guard against two things. If we interfere with the patient in his reproduction of the ideas that pour in on him, we may 'bury' things that have to be freed later with a great deal of trouble. On the other hand we must not over-estimate the patient's unconscious 'intelligence' and leave the direction of the whole work to it. If I wanted to give a diagrammatic picture of our mode of working, I might perhaps say that we ourselves undertake the opening up of inner strata, advancing *radially*, whereas the patient looks after the *peripheral* extension of the work.

Advances are brought about, as we know, by overcoming resistance in the manner already indicated. But before this we have as a rule another task to perform. We must get hold of a piece of the logical thread, by whose guidance alone we may hope to penetrate to the interior. We cannot expect that

through it, and we experiment how far we can advance with our present means and the knowledge we have acquired. We obtain preliminary information about the contents of the next strata by means of the pressure technique. We drop threads and pick them up again; we follow them as far as nodal points; we are constantly making up arrears; and every time that we pursue a file of memories we are led to some side-path, which nevertheless eventually joins up again. By this method we at last reach a point at which we can stop working in strata and can penetrate by a main path straight to the nucleus of the pathogenic organization. With this the struggle is won, though not yet ended. We must go back and take up the other threads and exhaust the material. But now the patient helps us energetically. His resistance is for the most part broken.

In these later stages of the work it is of use if we can guess the way in which things are connected up and tell the patient before we have uncovered it. If we have guessed right, the course of the analysis will be accelerated; but even a wrong hypothesis helps us on, by compelling the patient to take sides and by enticing him into energetic denials which betray his undoubted better knowledge.

We learn with astonishment from this that *we are not in a position to force anything on the patient about the things of which he is ostensibly ignorant or to influence the products of the analysis by arousing an expectation.* I have never once succeeded, by foretelling something, in altering or falsifying the reproduction of memories or the connection of events; for if I had, it would inevitably have been betrayed in the end by some contradiction in the material. If something turned out as I had foretold, it was invariably proved by a great number of unimpeachable reminiscences that I had done no more than guess right. We need not be afraid, therefore, of telling the patient what we think his next connection is going to be. It will do no harm.

Another observation, which is constantly repeated, relates to the patient's spontaneous reproductions. It may be asserted that every single reminiscence which emerges during an analysis of this kind has significance. An intrusion of irrelevant mnemic images (which happen in some way or other to be associated with the important ones) in fact never occurs. An exception which does not contradict this rule may be postulated for memories which, unimportant in themselves, are nevertheless

serve as a bridge in the sense that the association between two important memories can only be made through them.

The length of time during which a memory remains in the narrow defile in front of the patient's consciousness is, as has already been explained, in direct proportion to its importance. A picture which refuses to disappear is one which still calls for consideration, a thought which cannot be got rid of is one that needs to be pursued further. Moreover, a recollection never returns a second time once it has been dealt with; an image that has been 'talked away' is not seen again. If nevertheless this does happen, we can confidently assume that the second time the image will be accompanied by a new set of thoughts, or the idea will have new implications. In other words, they have not been completely dealt with. It often happens, on the other hand, that an image or thought re-appears in different degrees of intensity, first as a hint and later with complete clarity. This, however, does not contradict what I have just asserted.

Among the tasks presented by analysis is that of getting rid of symptoms which are capable of increasing in intensity or of returning: pains, and symptoms such as vomiting, which are due to sensations or contractures. While we are working at one of these symptoms we come across the interesting and not unwelcome phenomenon of 'joining in the conversation'.[1] The problematical symptom reappears, or appears with greater intensity, as soon as we reach the region of the pathogenic organization which contains the symptom's aetiology, and thenceforward it accompanies the work with characteristic oscillations which are instructive to the physician. The intensity of the symptom (let us take for instance a desire to vomit) increases the deeper we penetrate into one of the relevant pathogenic memories; it reaches its climax shortly before the patient gives utterance to that memory; and when he has finished doing so it suddenly diminishes or even vanishes completely for a time. If, owing to resistance, the patient delays telling for a long time, the tension of the sensation—of the desire to vomit—becomes unbearable, and if we cannot force him to speak he actually begins to vomit. In this way we obtain

[1] A very remarkable example of this was found in the case history of Fräulein von R. (p. [illegible]). It is also mentioned by Breuer on p. [illegible].

[illegible] psychical processes.

[illegible]

[illegible] three principal cases.

[illegible] If, for instance, the

patient feels she has been neglected, has been too little appreciated or has been insulted, or if she has heard unfavourable comments on the physician or the method of treatment. This is the least serious case. The obstacle can easily be overcome by discussion and explanation, even though the sensitiveness and suspiciousness of hysterical patients may occasionally attain surprising dimensions.

(2) If the patient is seized by a dread of becoming too much accustomed to the physician personally, of losing her independence in relation to him, and even of perhaps becoming sexually dependent on him. This is a more important case, because its determinants are less individual. The cause of this obstacle lies in the special solicitude inherent in the treatment. The patient then has a new motive for resistance, which is manifested not only in relation to some particular reminiscence but at every attempt at treatment. It is quite usual for the patient to complain of a headache when we start on the pressure procedure. For her new motive for resistance remains as a rule unconscious, and is expressed by the production of a new hysterical symptom. The headache indicates her dislike of allowing herself to be influenced.

(3) If the patient is frightened at finding that she is transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis. This is a frequent, and indeed in some analyses a regular, occurrence. Transference[1] on to the physician takes place through a false connection.[2] I must give an example of this. In one of my patients the origin of a particular hysterical symptom lay in a wish, which she had had many years earlier and had at once relegated to the unconscious, that the man she was talking to at the time

[1] [This is the first appearance of 'transference' (*Übertragung*) in the psycho-analytic sense [illegible] here [illegible] see Chapter VII, Section C of *The Interpretation of Dreams* (1900*a*), *Standard Ed.*, 5, [illegible] Freud dealt at length with the subject of transference [illegible] the first version of the case history of 'Dora' (1905*e*), *Standard Ed.*, 7, 116 ff.]

[2] [A long account of 'false connections' and the compulsion to associate was included above in a footnote on p. 67. [illegible] at the beginning of Section II of his first paper on 'The Neuro-Psychoses of Defence' (1894*a*).]

[illegible] The pressure procedure never failed to bring this memory back for us. When the obstacle had been made conscious and demonstrated the first difficulty was cleared out of the way. But a greater one remained. I was [illegible] to get [illegible] to proceed with the reproduction where apparently personal relations were concerned and where the third person coincided with the figure of the physician.

To begin with I was greatly annoyed at this increase in my psychological work, till I came to see that the whole process followed a law; and I then noticed, too, that transference of this kind brought about no great addition to what I had to do. For the patient the work remained the same: she had to overcome the distressing affect aroused by having been able to entertain such a wish even for a moment; and it seemed to make no difference to the success of the treatment whether she made this psychical repudiation the theme of her work in the historical instance or in the recent one connected with me. The patients, too, gradually learnt to realize that in these transferences on to the figure of the physician it was a question of a compulsion and an illusion which melted away with the completion of the analysis. I believe, however, that if I had neglected to make the nature of the 'obstacle' clear to them I should simply have given them a new hysterical symptom—though, it is true, a milder one—in exchange for another which had been generated spontaneously.

I have now given enough indications, I think, of the way in which these analyses have been carried out and of the observations that I have made in the course of them. What I have said may perhaps make some things seem more complicated than they are. Many problems answer themselves when we find ourselves engaged on such work. I did not enumerate the difficulties of the work in order to create an impression that, in view of the demands that a cathartic analysis makes on physician and patient alike, it is only worth while undertaking one in the rarest cases. I allow my medical activities to be governed by the contrary assumption, though I cannot, it is true, lay down the most definite indications for the application of the therapeutic method described in these pages without entering into an examination of the more important and comprehensive

topic of the treatment of the neuroses in general. I have often in my own mind compared cathartic psychotherapy with surgical intervention. I have described my treatments as psychotherapeutic operations, and I have brought out their analogy with the opening up of a cavity filled with pus, the scraping out of a carious region, etc. An analogy of this kind finds its justification not so much in the removal of what is pathological as in the establishment of conditions that are more likely to lead the course of the process in the direction of recovery.

When I have promised my patients help or improvement by means of a cathartic treatment I have often been faced by this objection: 'Why, you tell me yourself that my illness is probably connected with my circumstances and the events of my life. You cannot alter these in any way. How do you propose to help me, then?' And I have been able to make this reply: 'No doubt fate would find it easier than I do to relieve you of your illness. But you will be able to convince yourself that much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life[1] that has been restored to health you will be better armed against that unhappiness.'

[1] [The German editions previous to 1925 read 'nervous system'.]

APPENDIX A

The Chronology of the Case of Frau Emmy von N.

[illegible] to the Baltic estate as 1891.

[illegible]

[illegible]

four or five months.

[illegible]

months' must have been a slip.

[illegible]

caution against betraying his patient's identity, he altered the *time* of the treatment as well, but failed to carry the changes through consistently?[1] The whole problem must remain an open one.

[1] Cf. Freud's explanation in Chapter X of *The Psychopathology of Everyday Life* (1901b) of some of his own unnoticed slips in his *Interpretation of Dreams.* He accounted for these as unconscious retaliations for suppressions and distortions deliberately made by him in the material.

APPENDIX B

List of Writings by Freud dealing principally with Conversion Hysteria

[In the following list, the date at the beginning of each entry is that of the year during which the work in question was probably written. The date at the end is that of publication, and under that date fuller particulars of the work will be found in the Bibliography and Author Index. The items in square brackets were published posthumously.]

1886 'Observation of a Pronounced Hemi-Anaesthesia in a Hysterical Male.' (1886*d*)
1888 'Hysteria' in Villaret's *Handwörterbuch*. (1888*b*)
[1892 'A Letter to Josef Breuer.' (1941*a*)]
[1892 'On the Theory of Hysterical Attacks.' (With Breuer.) (1940*d*)]
[1892 'Memorandum "III".' (1941*b*)]
1892 'A Case of Successful Treatment by Hypnotism.' (1892–3*b*)
1892 'On the Psychical Mechanism of Hysterical Phenomena: A Preliminary Communication.' (With Breuer.) (1893*a*)
1893 Lecture: 'On the Psychical Mechanism of Hysterical Phenomena.' (1893*h*)
1893 'Some Points for a Comparative Study of Organic and Hysterical Motor Paralyses.' (1893*c*)
1894 'The Neuro-Psychoses of Defence.' Section I. (1894*a*)
1895 *Studies on Hysteria*. (With Breuer.) (1895*d*)
[1895 'Project for a Scientific Psychology.' Part II. (1950*a*)]
[1896 Draft K, Last Section. (1950*a*)]
1896 'Further Remarks on the Neuro-Psychoses of Defence.' (1896*b*)
1896 'The Aetiology of Hysteria.' (1896*c*)
1901–5 'Fragment of an Analysis of a Case of Hysteria.' (1905*e*)
1908 'Hysterical Phantasies and their Relation to Bisexuality.' (1908*a*)

1909 'Some General Remarks on Hysterical Attacks.' (1909*a*)
1909 *Five Lectures on Psycho-Analysis*, Lectures I and II. (1910*a*)
1910 'The Psycho-Analytic View of Psychogenic Disturbance of Vision.' (1910*i*)

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[illegible] of books and periodicals are in italics; [illegible] of papers are in [illegible] [illegible] are in accordance with the *World List of Scientific Periodicals* [illegible]. Further abbreviations [illegible] will be found in the List at the end of this bibliography. Numerals [illegible] refer to volumes; ordinary numerals refer to pages. The [illegible] in brackets at the end of each entry indicate the page or pages of this volume on which the work in question is mentioned. [illegible] the letters attached to the dates [illegible] with the corresponding entries in the [illegible] of Freud's writings to be contained in the last volume of the *Standard Edition*.

For non-technical authors, and for technical authors where no specific work is mentioned, see the General Index.

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(1940) See Freud, S. (1940*d*)

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[illegible] M. [illegible] *Leçons sur les maladies du système nerveux III*, Paris. [illegible]13, 15, 16,

[illegible] *Leçons du mardi à la Salpêtrière* [illegible] Paris. [illegible]

[illegible] Review of Breuer and Freud's 'Über den psychischen Mechanismus hysterischer Phänomene', *Brain*, 17, [illegible]125. (xv)

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[Trans.: [illegible] Detaching a Particular Syndrome from Neurasthenia under the Description "Anxiety Neurosis"', C.P., 1, 76; Standard Ed., 3.]
[illegible] 'Obsessions et phobies' (in French), [illegible], 1, 345. (69)
[Trans.: 'Obsessions and Phobias', C.P., 1, [illegible]; Standard Ed., 3.]
[illegible] 'Zur Kritik der "Angstneurose"', G.S., 1, [illegible]; G.W., 1, 357. (xxxv)
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[*Trans.*: *Jokes and their Relation to the Unconscious*, *Standard Ed.*, 8.]
[illegible] *Drei Abhandlungen zur Sexualtheorie*, Vienna. *G.S.*, 5, 3; *G.W.*, 5, 29. (xxvii, 21, [illegible]33)
[*Trans.*: *Three Essays on the Theory of Sexuality*, London, 19[illegible]; *Standard Ed.*, 7, 125.]
[illegible] 'Bruchstück einer Hysterie-Analyse', *G.S.*, 8, 3; *G.W.*, 5, [illegible]63. (xxv, 166, 247, 302, 310)
[*Trans.*: 'Fragment of an Analysis of a Case of Hysteria', *C.P.*, 3, 13; *Standard Ed.*, 7, 3.]
[illegible] 'Hysterische Phantasien und ihre Beziehung zur Bisexualität', *G.S.*, 5, 246; *G.W.*, 7, 191. (310)
[*Trans.*: 'Hysterical Phantasies and their Relation to Bisexuality', *C.P.*, 2, [illegible]; *Standard Ed.*, 9.]
[illegible] 'Allgemeines über den hysterischen Anfall', *G.S.*, 5, 255; *G.W.*, 7, 235. (17, 311)
[*Trans.*: 'Some General Remarks on Hysterical Attacks', *C.P.*, 2, [illegible]00; *Standard Ed.*, 9.]
[illegible] 'Analyse der Phobie eines fünfjährigen Knaben', *G.S.*, 8, [illegible]29; *G.W.*, 7, 243. (257)
[*Trans.*: 'Analysis of a Phobia in a Five-Year-Old Boy', *C.P.*, 3, [illegible]49; *Standard Ed.*, 10, 3.]
[illegible] *Über Psychoanalyse*, Vienna. *G.S.*, 4, 349; *G.W.*, 8, 3. ([illegible], xxvii, 47, 90, 105, 181, 3[illegible]1)
[*Trans.*: 'Five Lectures on Psycho-Analysis', *Am. J. Psychol.*, 21 [illegible], 181; *Standard Ed.*, 11.]
[illegible] 'Die psychogene Sehstörung in psychoanalytischer Auffassung', *G.S.*, 5, [illegible]; *G.W.*, 8, [illegible]
[*Trans.*: 'The Psycho-Analytic View of Psychogenic Disturbance of Vision', *C.P.*, 2, [illegible]; *Standard Ed.*, 11.]
[illegible] 'Über "wilde" Psychoanalyse', *G.S.*, 6, [illegible]; *G.W.*, 8, [illegible] (257)
[*Trans.*: '"Wild" Psycho-Analysis', *C.P.*, 2, 29[illegible]; *Standard Ed.*, 11.]
[illegible] 'Zur Onanie-Diskussion', *G.S.*, 3, 3[illegible]4; *G.W.*, 8, 33[illegible]. ([illegible]8)
[*Trans.*: 'Contributions to a Discussion on Masturbation', *Standard Ed.*, 12.]
[illegible] 'Erfahrungen und Beispiele aus der analytischen Praxis', *Int. Z. Psychoan.*, 1, [illegible]. Partly reprinted *G.S.*, 11, [illegible]; *G.W.*, 10, 4[illegible]. Partly [illegible] in *Die Traumdeutung*, *G.S.*, 3, 4[illegible] [illegible] and [illegible]; *G.W.*, 2-3, [illegible]8 [illegible] 4[illegible] [illegible] 4[illegible] [illegible]
[*Trans.*: 'Observations and Examples from Analytic Practice', *Standard Ed.*, 13, [illegible]. [illegible] also partly incorporated in *The Interpretation of Dreams*, *Standard Ed.*, 4, [illegible] and 5, 4[illegible].]
[illegible] '[illegible] des Narzissmus', *G.S.*, 6, [illegible]; *G.W.*, 10, [illegible]8. ([illegible])

[*Trans.*: 'On Narcissism: an Introduction', *C.P.*, 4, [illegible]; *Standard Ed.*, 14.]

[illegible] 'Zur Geschichte der psychoanalytischen Bewegung', *G.S.*, 4, [illegible]; *G.W.*, 10, 44. [illegible]

[*Trans.*: 'On the History of the Psycho-Analytic Movement', *C.P.*, 1, 287; *Standard Ed.*, 14.]

[illegible] 'Triebe und Triebschicksale', *G.S.*, 5, 443; *G.W.*, 10, [illegible] (xix)

[*Trans.*: 'Instincts and their Vicissitudes', *C.P.*, 4, 60; *Standard Ed.*, 14.]

[illegible] 'Die Verdrängung', *G.S.*, 5, [illegible]; *G.W.*, 10, [illegible]

[*Trans.*: 'Repression', *C.P.*, 4, 84; *Standard Ed.*, 14.]

[illegible] 'Das Unbewusste', *G.S.*, 5, [illegible]; *G.W.*, 10, [illegible] 45, 194, 212

[*Trans.*: 'The Unconscious', *C.P.*, 4, [illegible]; *Standard Ed.*, 14.]

[illegible] note to Ernest Jones's 'Professor Janet über die Psychoanalyse', *Int. Z. Psychoan.*, 4, 42. (xiii)

[*Trans.*: *Standard Ed.*, 2, xiii.]

[illegible] 'Trauer und Melancholie', *G.S.*, 5, [illegible]; *G.W.*, 10, [illegible]

[*Trans.*: 'Mourning and Melancholia', *C.P.*, 4, [illegible]; *Standard Ed.*, 14.]

[illegible] *Jenseits des Lustprinzips*, Vienna. *G.S.*, 6, [illegible]; *G.W.*, 13, [illegible] (xix–xx, xxi, xxvii, 189, 194)

[*Trans.*: *Beyond the Pleasure Principle*, London, [illegible]; *Standard Ed.*, 18, 7.]

[illegible] *Massenpsychologie und Ich-Analyse*, Vienna. *G.S.*, 6, [illegible]; *G.W.*, 13, 73. (271)

[*Trans.*: *Group Psychology and the Analysis of the Ego*, London, [illegible] New York, [illegible]; *Standard Ed.*, 18, [illegible]]

[illegible] 'Psychoanalyse' und 'Libidotheorie', *G.S.*, 11, 201; *G.W.*, 13, 211. (xxvii)

[*Trans.*: 'Two Encyclopaedia Articles', *C.P.*, 5, [illegible]; *Standard Ed.*, 18, 235.]

[illegible] 'A Short Account of Psycho-Analysis', published as 'Psycho-analysis: Exploring the Hidden Recesses of the Mind', [illegible] Vol. 2 of *These Eventful Years*, London and New York. *Standard Ed.*, 19. (xxvii)

[German Trans.: 'Kurzer Abriss der Psychoanalyse', *G.S.*, 11, 183; *G.W.*, 13, 405. [illegible]]

[illegible] 'Notiz über den "Wunderblock"', *G.S.*, 6, [illegible]; *G.W.*, 14, 3. (189)

[*Trans.*: 'A Note upon the "Mystic Writing-Pad"', *C.P.*, 5, [illegible]; *Standard Ed.*, 19.]

[illegible] *Selbstdarstellung*, Vienna. *G.S.*, 11, 119; *G.W.*, 14, [illegible] (xi, xxii, xxv, xxviii, 21, 41, 308)

[*Trans.*: *An Autobiographical Study*, London, [illegible]; *Autobiography*, New York, [illegible]; *Standard Ed.*, 20.]

[illegible] 'Josef Breuer', *G.S.*, 11, [illegible]; *G.W.*, 14, [illegible]

[*Trans.*: *Int. J. Psycho-Anal.*, 6, [illegible]; *Standard Ed.*, 19.]

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[illegible]
J. abnorm. (soc.) Psychol., 9, 400. [illegible]
[illegible]
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'Wesen der Hysterie', *Berl. klin. Wschr.*, 27, 553 (191, 203, 242, 245)
PITRES, A. (1891) *Leçons cliniques sur l'hystérie et l'hypnotisme*, Paris. (77)
ROMBERG, M. H. (1840) *Lehrbuch der Nervenkrankheiten des Menschen*, Berlin. (220)
SCHOPENHAUER, A. (1844) *Die Welt als Wille und Vorstellung* (2nd ed.), Leipzig. (xxii)
STRÜMPELL, A. VON (1892) *Über die Entstehung und die Heilung von Krankheiten durch Vorstellungen*, Erlangen. (245)
(1896) Review of Breuer and Freud's *Studien über Hysterie*, *Dtsch. Z. Nervenheilk.*, 8, 159. (xv)
WESTPHAL, C. F. O. (1877) 'Über Zwangsvorstellungen', *Berl. klin. Wschr.*, 14, 669 and 687. (256)

LIST OF ABBREVIATIONS

G.S.	=	Freud, *Gesammelte Schriften* (12 vols.), Vienna, 1924–34
G.W.	=	Freud, *Gesammelte Werke* (18 vols.), London, from 1940
C.P.	=	Freud, *Collected Papers* (5 vols.), London, 1924–50
Standard Ed.	=	Freud, *Standard Edition* (24 vols.), London, from 1953
S.K.S.N.	=	Freud, *Sammlung kleiner Schriften zur Neurosenlehre* (5 vols.), Vienna, 1906–22
S.P.H.	=	*Selected Papers on Hysteria and Other Psychoneuroses*, New York, 1909–20

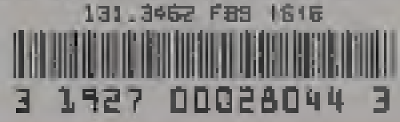
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T[illegible] index includes the names [illegible] authors. It also [illegible] the names of [illegible] authors where [illegible] reference is made [illegible] to specific works. For references to [illegible] technical works, the Bibliography [illegible] consulted. [illegible] the compilation of the index was undertaken by Mrs [illegible]

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